AUTHORIZATION TO OBTAIN MEDICAL RECORDS

I hereby authorize ***Westside Medical Associates of Los Angeles*** to obtain medical records and/or data pertaining to:

Patient's Name:	**Date of Birth:**	**SS#**:
Street Address:	**City, State, Zip Code:**	**Phone Number:**

Please specify what records should be released:

- □ **All records**
- □ **All records between the dates of _____& _____.**
- □ **Records pertaining to_____.**
- □ **Lab Results**
- □ **Radiology Results**

Specified method of release:

- □ **We will Pick-up records on _____**
- □ **Please Mail to _____**
- □ **Please Fax to _____**

This authorization shall be in effect until: (check one of the following)

- □ **Date_____**
- □ **The happening of the following event:_____.**

I understand that, as set in forth in the facility's Privacy Notice, I have the right to revoke this authorization, in writing, at any time by sending written notification to Westside Medical Associates of Los Angeles Medical Records Department.

Patient's name:_____ Date:_____

Patient's signature _____
(Parent or Legal Guardian, Power of Attorney)