RECORDS RELEASE AUTHORIZATION

To: _____
DOCTOR OR HOSPITAL

I hereby authorize and request you to release the complete records in your possession concerning my illness and/or treatment to:

Hisham El-Bayar, M.D.
1010 W. La Veta Avenue #470
Orange, CA 92868
(714) 835-8300
FAX (714) 835-8304

_____ for the period from _____ to _____

_____ all records.

Patient Name: _____

DOB: _____ MR# _____

Patient Signature: _____ Date: _____

Witness: _____ Date: _____