RECORDS RELEASE

TO: ____
Name of Doctor / Medical Group or Clinic

____
Address / City / State / Zip

____
Telephone / Fax

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I HEREBY AUTHORIZE AND REQUEST YOU TO RELEASE TO:

Ann L. Mai, M.D.
4950 Barranca Parkway, Suite 207
Irvine, California 92604
Phone (949) 262-9700 -- (949) 262-0700 Fax

THE COMPLETE MEDICAL RECORDS IN YOUR POSSESSION, FOR PERIOD FROM ________________ TO ________________. If there is a charge for this service I (the patient) am responsible for the fee. Do not bill my new doctor's office.

Name of Patient: ________________________________ DOB: ________________

Patient's SSN: ______________________________ Telephone: ________________

Patient's Current Address: ____
Address / City / State / Zip

Signature: ______________________________________ Date: ________________

Print Name: ________________________________

If not signed by the patient, please indicate relationship:

- ☐ parent or guardian of a minor patient
- ☐ guardian or conservator of an incompetent patient
- ☐ beneficiary or personal representative of deceased patient

Witness Signature: ____________________________

Witness Name: ________________________________