# AUTHORIZATION TO RELEASE MEDICAL RECORDS

I hereby authorize:

(Medical Practice name) ____________________________________________

to release medical records on the following patient:

Name____________________________________

Address___________________________________

Telephone__________________________________

Date of Birth________________________________

Records are to be transferred to:

**Scott Tong, MD, Inc.**

**3655 Lomita Blvd., Suite 318**

**Torrance, CA 90505**

______________________________________________________________________

Patient Signature Date