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