**RECORDS RELEASE**

DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

TO: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOCTOR OR HOSPITAL

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS/PHONE NUMBER

I HEREBY AUTHORIZE AND REQUEST YOU TO RELEASE TO:

GABRIEL CARABULEA, M.D.

30250 RANCHO VIEJO ROAD, SUITE C

SAN JUAN CAPISTRANO, CA 92675

FAX: 949-218-4688

THE COMPLETE MEDICAL RECORDS IN YOUR POSSESSION CONCERNING MY ILLNESS AND/OR TREATMENT DURING THE PERIOD

FROM \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ TO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PATIENT NAME

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SIGNATURE OF PATIENT OR REPRESENTATIVE