RELEASE OF MEDICAL INFORMATION

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PHONE: (661) 665-0505
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I hereby authorize: ____

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to disclose to: ____

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all information and records with respect to myself/my minor child, relating to diagnosis, treatment, prognosis, medical history, physical and mental condition and evaluation thereof.

Such information is to be used with respect to treatment which may be rendered to me/my minor child as a patient.

I agree to indemnify and hold you harmless from any liability arising from the release of said information. A copy of this authorization shall serve the same purpose as the original and shall be valid.

This authorization is valid until written notification is received requesting cancellation of this authorization.

________________________ ____________________________
Patient Name (Please PRINT) Patient Signature, or parent if patient is minor

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Patient Birth Date Social Security Number Date of Signature