RECORD RELEASE AUTHORIZATION

TO:_____

Address:_____

Phone #:_____ Fax #:_____

I HEREBY AUTHORIZE AND REQUEST YOU TO RELEASE TO:

HUONG TRAN QUY D.O.

9559 BOLSA AVE., SUITE D

WESTMINSTER, CA 92683

(TEL) 714-531-5754 (FAX) 714-531-5824

_____ THE COMPLETE HISTORY AND PHYSICAL RECORDS IN YOUR POSSEION, CONCERNING MY ILLNESS AND OR TREATMENT DURING THE PERIOD

FROM_____ TO_____

_____ THE IMMUNIZATION RECORDS ONLY

NAME:_____

ADDRESS:_____

DOB:_____ _____

SIGNATURE:_____

(IF RELATIVE, STATE RELATIONSHIP)