

# SANDRA S. KWAK M.D. INC.

520 SUPERIOR AVENUE, SUITE 210, NEWPORT BEACH, CA 92663

PHONE: 949.645.8800 FAX: 949.645.8844

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## REQUEST FOR RELEASE OF MEDICAL RECORDS

To: \_\_\_\_\_  
Name of Physician, Hospital or Facility

Address: \_\_\_\_\_  
Address City State Zip Code

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

From: \_\_\_\_\_  
Name of Patient

### Re: Request for Release of Medical Records

I hereby request that my medical records, without limitations, including any HIV test results and/or treatment and any psychiatric records, be released to:

**Sandra S. Kwak M.D., Inc.  
520 Superior Avenue, Suite 210  
Newport Beach, CA 92663**

This authorization releases my medical records for the following designated purpose:

\_\_\_\_\_

This release is valid for 30 days after this date.

**I understand that I am entitled to receive a copy of this release.**

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Patient's Date of Birth

\_\_\_\_\_  
Print Patient's Name

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Print Name of Legal Guardian (relationship), if applicable

\_\_\_\_\_  
Witness