SANDRA S. KWAK M.D. INC.

520 SUPERIOR AVENUE, SUITE 310, NEWPORT BEACH, CA 92663

PHONE: 949.645.8800   FAX: 949.645.8844

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 310   (or)   ______________________

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.

______________________________   ______________________

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