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Stanley R. Klein, M.D., FACS
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Megan R. Linnebur, M.D.
Roman A. Litwinski, M.D., FACS
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Houman Saedi, M.D., FACS
Houman Solomon, M.S., M.D., FASMBS, FACS
Aileen M. Takahashi, M.D., FACS

MEDICAL RECORDS RELEASE FORM

Release Records From: ______________________________

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Release Records To: Association of South Bay Surgeons
23451 Madison Street, Suite 340
Torrance, CA 90505

I hereby authorize and request you to release the complete medical records in your possession concerning my illness and/or treatment during the period from:

DATE: ____________________ **TO:** ____________________

Please release all medical records ☐

Special request: ______________________________

Patient's Name: ______________________________

Date of Birth: ____________________

SS #:____________________

Signed: ______________________________ Date: ____________

Relationship to Patient: ____________________

Witness: ______________________________ Date: ____________

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