KATHRYN M. GARDNER, M.D.
242 26TH STREET, SUITE A
SANTA MONICA, CA 90402
(310) 451-3911 (310) 458-4402, Fax

AUTHORIZATION FOR RELEASE OF RECORDS TO DR. GARDNER

I HEREBY AUTHORIZE AND REQUEST YOU TO RELEASE MY MEDICAL RECORDS TO KATHRYN M. GARDNER, M.D. AT THE ADDRESS ABOVE.

Name of Physician, Health Provider or Hospital:

_____

Address:

_____

Dates of Medical Records_____

Records To Include the Following_____

Name of Patient:_____

Authorized Signature_____Date_____

State Relationship, if not Patient

Date of Birth _____

KATHRYN M. GARDNER, M.D.
242 26TH STREET, SUITE A
SANTA MONICA, CA 90402
(310) 451-3911 (310) 458-4402, Fax

AUTHORIZATION FOR RELEASE OF DR. GARDNER'S RECORDS

I HEREBY AUTHORIZE AND REQUEST DR. KATHRYN GARDNER TO RELEASE MY MEDICAL RECORDS TO THE INDIVIDUAL, PHYSICIAN OR HEALTH CARE PROVIDER SPECIFIED BELOW:

Name of Individual, Physician, or Health Care Provider

_____

Address:

_____

Dates of Medical Records_____

Records To Include the Following_____

Name of Patient:_____

_

Authorized Signature_____Date_____

State Relationship, if not Patient

Date of Birth _____