

REQUEST FOR RELEASE OF MEDICAL RECORDS

To: _____

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:

**Eric Wechsler, M.D. Inc.
320 Superior Ave. Suite 250
Newport Beach, CA 92663**

Phone: 949-642-4974

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