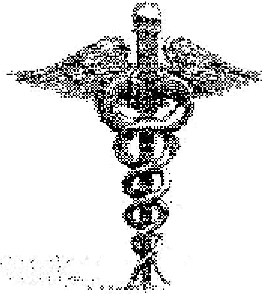
MEDICAL RECORDS RELEASE AUTHORIZATION



DR. DZUNG PHAM

15435 JEFFREY RD, SUITE # 127 IRVINE, CA 92620

TEL: 949-654-8455 FAX: 888-805-6665

EMAIL : ivuccontact@gmail.com

TO ____

I here by authorize and request you to release the following records : ____

____

Any information including the diagnosis and records of any treatment rendered to me during the period from ____________

____________________ to ____________________

NAME : ____________________ DOB : ____________________

ADDRESS : ____________________ PHONE : ____________________

Signature : ____________________ Date : ____________________ Witness : ____________________