Medical Office of:
Haya R Rubin MD PhD
555 Bryant St., #267
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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

To: Haya R Rubin MD PhD____________

Address: 555 Bryant St., #267 _______________

Palo Alto, CA 94301-1704___________

I hereby authorize and request a copy of the medical records (to include EKG tracings) of

MEDICAL RECORDS

Special Request: ____.

Patient Full Name(Print): ___________________________ DOB: ____________

To be released to:

DOCTOR: ____

ADDRESS: ____

____

I hereby release you from all legal responsibility and liability that may arise from this act that I have authorized.

_____________________________________ ____________________________
Patient Signature(Legal Guardian) Date:

Printed Name of Signer: _____________________________________

_____________________________________ _____________________________
Witness Date:

Printed Name of Signer: _____________________________________