Medical Office of:

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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

To: **Haya R Rubin MD PhD_____**

Address: **555 Bryant St., #338 _____**

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: _____