

RECORDS RELEASE AUTHORIZATION

TO: _____

ADDRESS: _____

CITY/STATE/ZIP: _____

PHONE : _____

I HEREBY AUTHORIZE AND REQUEST YOU TO RELEASE TO :

DAVID L.J. WARDLE, M.D.
360 SAN MIGUEL DRIVE, SUITE 406
NEWPORT BEACH, CA. 92660
(949) 719-2826
FAX (949) 759-5458

_____ HISTORY & PHYSICAL	_____ OPERATIVE REPORT
_____ E.R. RECORD	_____ CLINICAL RECORD
_____ ALL	_____ OTHER

INFORMATION FROM THE MEDICAL RECORDS OF:

PATIENT NAME: _____

BIRTH DATE AND/OR SOCIAL SECURITY: _____

DATES OF TREATMENT: _____

PHONE _____

PATIENT OR REPRESENTATIVE _____

DATE _____ WITNESS _____