RECORDS RELEASE

DATE:____________________________

TO: ____

DOCTOR OR HOSPITAL

____

ADDRESS/PHONE NUMBER

I HEREBY AUTHORIZE AND REQUEST YOU TO RELEASE TO:

GABRIEL CARABULEA, M.D.
665 CAMINO DE LOS MARES #208
SAN CLEMENTE, CA 92673
FAX: 949-218-4688

THE COMPLETE MEDICAL RECORDS IN YOUR POSSESSION CONCERNING MY ILLNESS AND/OR TREATMENT DURING THE PERIOD

FROM ______________________ TO ____________________

____

PATIENT NAME

____

SIGNATURE OF PATIENT OR REPRESENTATIVE