Mulholland

BRAIN SPINE

Medical Records Release Form

I hereby authorize and request you to release,

TO: _____
DOCTOR OR HOSPITAL

_____
ADDRESS

_____

From: Celene B. Mulholland, M.D.
630 S Raymond Ave. Ste #330
Pasadena, CA 91105

The complete medical records in your possession concerning my illness and/or treatment during the period from:_____ to _____.

SIGNED:_____ DATE:_____
PATIENT OR NEAREST RELATIVE

PRINTED:_____

Patient: _____

DOB: _____