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Records Release

Date: _____

To: _____
(Doctor or Hospital)

_____
(Address)

I hereby authorize and request you to release:

To: **Uthaiah P. Kokkalera, M.D.**
18250 Roscoe Blvd.
Suite 335
Northridge, CA 91325

Fax: (818) 700-7901

The complete medical records in your possession, concerning my illness and/or treatment during the period:

From: _____To: _____

Signed: _____
(Patient or nearest relative)

Print name: _____

Witness: _____