

**B R A I N T U M O R C E N T E R**  
AT SAINT JOHN'S HEALTH CENTER

**\*\*\* AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS \*\*\***

**PATIENT INFORMATION (Please Print)**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

SSN: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Please Release My Records From**

NAME: \_\_\_\_\_

TELEPHONE: \_\_\_\_\_

FAX: \_\_\_\_\_

**TO:**

**DANIEL F. KELLY, M.D.**  
2200 SANTA MONICA BOULEVARD  
SANTA MONICA, CA 90404  
PHONE: 310-582-7450  
FAX: 310-582-7495

**Please send these medical records no later than \_\_\_\_\_**  
(DATE)

Please release a copy of my records, including progress notes, operative notes, laboratory results, imaging reports (e.g., MRI and CT), diagnostic tests and pathology reports.

BY MY SIGNATURE, I AUTHORIZE RELEASE OF MY MEDICAL RECORDS TO:  
DANIEL KELLY, M.D.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_