

NEUROSCIENCE INSTITUTE & BRAIN TUMOR 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. & DR. AMIN KASSAM, 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. and DR. AMIN KASSAM, M.D.

SIGNATURE: _____ DATE: _____