

**WESTSIDE MEDICAL ASSOCIATES**  
**-----OF LOS ANGELES-----**

*99 N. LA CIENEGA BLVD, STE 203, BEVERLY HILLS, CA 90211*

*NORMAN E. LEPOR, M.D., FACC, FAHA      HOOMAN MADYOON, M.D., FACC, FACP*

**RECORDS RELEASE**

*Date:* \_\_\_\_\_

*To:* \_\_\_\_\_

*Doctor or Hospital*

\_\_\_\_\_  
*Address*

*I hereby authorize and request you to release:*

*To:* \_\_\_\_\_

*Doctor or Hospital*

\_\_\_\_\_  
*Address*

*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:* \_\_\_\_\_