



Conejo Pain Specialists Medical Group, Inc.

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MEDICAL RECORDS RELEASE FORM

(Will be processed within 15 days)

I, _____ (if a minor, parent or guardian's name), DOB (mm/dd/yy) ____/____/____, hereby authorize and request to release records in the possession of **Conejo Pain Specialists Medical Group, Inc.** to the following (myself, doctor's office, hospital, facility, etc):

Medical Facility: Doctor's Office/ MRI Facility/Hospital:

Name of Facility: _____

Address: _____

Phone #: _____ Fax #: _____

Specialty: _____

Family/Relative/Friend:

Name: _____

Address: _____

Phone #: _____ Relation: _____

Other:

Name: _____

Address: _____

Phone #: _____ Relation: _____

Business type (if applicable): _____

Requested Records to be released (Please specify):

During the period from: _____ to _____

Patient's Signature

Date

DISCLAIMER:

The information contained in this message is intended for the sole confidential use of the designated recipients and may contain confidential information. If you have received this information in error, any review, dissemination, distribution or copying of this information is strictly prohibited. If you have received this communication in error, please notify us immediately by telephone and return the original message to us by mail or if electronic, reroute back to the sender. Thank you.

Updated 07/10/2015