Conejo Pain Specialists Medical Group, Inc.
Kamyar Assil, MD
Rick DeLeon, PA-C

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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: _____

Adress: _____

Phone #: _____ **Relation:** _____

☐ **Other:**

Name: _____

Adress: _____

Phone #: _____ **Relation:** _____

Business type (if applicable): _____

Requested Records to be released (Please specify):

_____

_____

_____

During the period from: _____ to _____

_____ _____

Patient's Signature **Date**

Updated 07/10/2015