Conejo Pain Specialists Medical Group, Inc.

Kamyar Assil, MD
Rick DeLeon, PA-C

MEDICAL RECORDS RELEASE AUTHORIZATION

Doctor's Office, MRI Facility, Hospital, etc.

To: Phone # Fax # ______________________________

(Doctor's Office,MRI Facility, Hospital)

I, ______________________________, Date of Birth ______________hereby authorize and request you to release to:

( ) **CONEJO PAIN SPECIALISTS MEDICAL GROUP, INC**
3366 E. Thousand Oaks Blvd. 2nd Floor. Thousand Oaks, CA 91362
Phone: 805-497-8616 | Fax: 805-496-5585

( ) **SAXON SURGICAL CENTER**
430 E. Avenida De Los Arboles , Suite 101 Thousand Oaks, CA 91360
Phone: 805-241-0151 | Fax: 805-241-0111

All records for:______________________________DOB:______________

In your possession concerning:______________________________

During the period from: ______________________ to ______________________

______________________________ ______________

Patient's Signature Date

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