VILLA MEDICAL ARTS
Physicians and Surgeons

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AUTHORIZATION FOR RELEASE OF PATIENT HEALTH INFORMATION

Patient Name _____ Birthdate _____ Social Security_____

Address _____

City _____ State _____ Zip_____ Phone Number _____

Authorization:

FROM: _____
(health care provider)

_____
Address City State Zip

_____
Phone Fax

TO: _____
(Health care provider)

_____
Address City State Zip

Purpose of Release:

Progress Notes_____ Hospital Records_____ History & Physical_____ Lab Results_____

X-ray Results_____ Immunization Records_____ Diagnostic_____

Consultations____ All Records_____

Signature of Patient: _____ Date: _____

If not the patient, relationship and signature of legally authorized representative:

_____Date: _____

FAMILY MEDICINE
Anthony Lin, M.D., P.C.
Eyad Homedi, M.D., P.C.

INTERNAL MEDICINE
Inna Milgram, M.D., P.C.