Record Release Authorization

To:_____

_____

I hearby authorize and request you to release my records to

Wesley A. King, M.D.
120 S. Spalding Dr.
Suite 400
Beverly Hills, CA 90057
310-385-1918
310-385-9007 fax

The complete history records in your possession, concerning my illness and/or treatment during the period from _____ to _____.

Patient Name:_____
Address:_____
_____
_____
_____

Patient Signature:_____Date_____

Witness Signature:_____Date_____

I understand that I have a right to receive a copy of my Medical Records, with this authorization, if requested by me.

Note to the Provider: Failure by a physician or podiatrist to provide the requested records within 15 days of receipt of the request and authorization may be construed to be a violation of section 2225.5 of the Medical Practice Act and may result in further action by the Medical Board.

This authorization will expire 90 days from the signature date.
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I understand that I have the right to revoke this authorization at any time. By signing below, I revoke the above signature to release records to the physician listed.

Signature_____Date_____