Gary Briskin, D.P.M.
Bob Baravarian, D.P.M.
Justin Franson, D.P.M.
Avanti Redkar, D.P.M.
Stefan Feldman, D.P.M.
Charles Kelman, D.P.M.
Shahdad Saeedi, D.P.M.

MEDICAL RECORDS RELEASE REQUEST

I, _____born on_____, hereby authorized and request the release of:

☐ X-Rays Imaging*
☐ MRI Report / ☐ MRI Imaging*
☐ CT Scan Report / ☐ CT Scan Imaging*
☐ Progress Notes
☐ Other: _____

☐ Myself (the patient)
☐ Relative / Other — Name of Relative / Other:_____
☐ Physician / Hospital — Name of Physician / Hosp.:_____
Phone: _____ Fax:_____

I was seen by:

I was seen in:
☐ Santa Monica (2121 Wilshire Blvd., Suite 101)
☐ Valencia (26357 McBean Parkway, Suite 250)
☐ Beverly Hills (150 N. Robertson Blvd., Suite 205)
☐ Sherman Oaks (5170 Sepulveda Blvd., Suite 100)
☐ Santa Barbara (1919 State St., Suite 206)
☐ South Bay (5230 Pacific Concourse Dr., Suite 100)
☐ West Hills (7230 Medical Ctr. Dr., Suite 503)
☐ Simi Valley (2941 Cochran St., Suite 5)
☐ Mid-Wilshire(5901 W. Olympic Blvd., Suite 509)

I would like records:
☐ Mailed to (address):_____
☐ Faxed to (number): _____
☐ Will pick up in person (office location): _____

*** Medical imaging** can only be copied onto a CD and will need to be picked-up in person or mailed out.

Medical records will be released **one week** from the receipt of the initial request. For ***urgent*** processing please contact the office at 310-828-0011 or fax to 310-828-2001. Thank you.

Patient's Signature: _____Date: _____

Release by: _____Date: _____

Received by: _____Date: _____