



Eve Surgical Center
 10150 National Blvd. Los Angeles, CA 90034
 Phone 310.839.7770 Fax 310.204.3190

Medical Record Request

By signing this authorization, I authorize you to use and/ or disclose certain protected health information (PHI) about me to:

Please mail to: 10150 National Blvd. Los Angeles, CA 90034
 fax to: 310-204-3190

Dear Dr. _____,

I authorize you to release a copy of the medical records of

 NAME OF PATIENT

 DATE OF BIRTH

Covering the period of: _____ to present.

The information will be used or disclosed for the following purpose: Any information pertaining to the procedure including medical records. If requested by the patient, purpose may be listed as "at the request of the individual." The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information.

This authorization will expire on _____

I release you from all legal responsibility or liability that may arise form this authorization.

I do not have to sign this authorization in order to receive treatment from Eve Surgical Center. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPPA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at the address ABOVE.

 SIGNATURE OF PATIENT

 DATE

 PRINT NAME OF PATIENT