BEST ANGELS PEDIATRICS
7950 Cherry Ave. STE 105. Fontana, CA 92336. Phone: (909) 434-1657 Fax: (909) 231-6231

Authorization to Release Medical Information

Patient Name:	
Date of Birth:	
Phone Number:	

I hereby authorize _____to disclose my health records to
(former physician's office)
_____ for continuation of my medical care.
(recipient of medical records)

☐	Entire Record:
☐	Specific Information:
☐	Other:

Please send the medical record information to:

Physician's Name:	Best Angels Pediatrics, Imad Akel, MD
Phone Number:	(909) 434-1657
Address:	7950 Cherry Ave, Ste 105, Fontana, CA 92336
Fax Number:	(909) 231-6231

I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on authorization. Unless otherwise revoked, **this authorization will expire 90 days from the date the authorization was signed**. The facility, its employees, and physicians are hereby release from legal resposbility or liability from disclosure of the above information to the extent indicated and authorized herein

PATIENT SIGNATURE: _____ DATE: _____

LEGAL GUARDIAN _____ DATE _____