Jacklin Poladian, M.D., Inc.
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Authorization to Release Medical Records From Dr J. Poladian to Patients and Other Institutions

I am requesting the release of my records from:

Doctor/Hospital_____

Address_____

Phone_____

Fax_____

I _____, hereby request and authorize my medical information, including highly confidential health records, be sent to _____. Please furnish the following information:

1. History and Physical Examinations
2. Progress Notes
3. Consultation Notes
4. Any laboratory results
5. Any imaging or other diagnostic test results
6. Hospital Admission Notes and Discharge Summaries
7. Immunization records
8. Pathology
9. EKG

I have the responsibility to pay any fees associated with transfer of my records. There is a $0.25 per page charge and a $25 clerical fee associated with processing my request. I agree to pay all record request fees prior to transfer of my records.

Patient or Guardian Signature_____

Print Patient Name_____

Date_____

Reason for Request: _____

Your request will be processed within 14 days.