Jacklin Poladian, M.D., Inc.
800 S. Fairmount Ave., Suite 420
Pasadena, CA 91105
(626) 200-4500 office
(626) 795-0704 fax

Authorization to Release Medical Records

I am requesting the release of my records from:

Doctor/Hospital _____

Address _____

Phone _____

Fax _____

I _____ Date of Birth _____ , hereby request and authorize my medical information, including highly confidential health records, be sent to Dr. Jacklin Poladian. 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.

Patient or Guardian Signature _____

Print Patient Name _____

Date _____

*This form will expire 12 months from date of signature