KOCHAN PAIN TREATMENT CENTER
Andrew Kochan, M.D. | Diplomate, Board of Physical Medicine

MEDICAL RECORDS RELEASE AUTHORIZATION

DATE _____

TO _____

_____

_____

RE: PATIENT _____

To facilitate my treatment of the above-referenced patient, I would appreciate receiving copies of the following medical records:

[ ] All Records [ ] History & Physical [ ] X-Ray Report(s)

[ ] X-Ray Film(s) [ ] Diagnosis & Treatment [ ] Lab & Special Studies (report & films)

Receipt of records would be appreciated prior to the patient's scheduled appointment on _____

[ ] Other _____

_____

AUTHORIZATION FOR RELEASE OF INFORMATION:

I hereby authorize any hospital, clinic, physician, surgeon, practitioner, pharmacy, or other healthcare provider to furnish Andrew Kochan, M.D., or his representatives at the Kochan Pain Treatment Center, any and all information concerning any mental or physical condition, including alcohol or drug abuse, I may have suffered. A copy of this authorization shall be considered as valid as the original.

_____ _____
Patient Signature Date

_____ _____
Signature of Parent or Legal Guardian if Patient is a Minor Date

4835 Van Nuys Blvd, Suite 100, Sherman Oaks, CA 91403 | 818.995.9331 tel | 818.995.9334 fax
KochanCenter.com