Coast OB-GYN
DR. HIND AL-AZAWI

Medical Records Release

Date: _____

To:

_____

_____

I hereby authorize you to release to:

Coast OB-GYN
366 San Miguel Dr. #209
Newport Beach, CA 92660
Phone: 949-520-7078 Fax: 949-209 4177

*any information including the diagnosis and records of any treatment or examination rendered to me during the period from*_____ *to* _____

_____
Print Name

_____
Signature

_____ _____
Witness *Date of Birth*