Ellen McDonald MD
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800 Fairmount Ave, Suite 210
Pasadena CA 91105
626-872-4195 office
626-628-1836 fax

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

To: _____
Physician Name

_____
Physician Address

_____
Physician Fax Number

Patient Name: _____

Date of Birth: _____

I request and authorize my medical information and records concerning history, treatment, examinations, and/or hospitalizations be sent to:

Ellen McDonald, MD
800 Fairmount Ave, Suite 210
Pasadena CA 91105

626-628-1836 fax

_____ _____
Patient or Guardian Signature Date