SOUND ADVICE

AUTHORIZATION TO REQUEST RELEASE OF MEDICAL RECORDS

Patient Name: _____

Date of Birth: _____

Dear Provider:

I hereby authorize Sound Advice, 4001 W. Alameda Ave., Suite 101, Burbank, CA, 91505, 818-841-0066, to request and release any and all medical records from your office in regard to the above-named patient.

NAME OF MEDICAL FACILITY:

Doctor's Name: _____

Address: _____

City, State and Zip: _____

Telephone Number: _____

Authorized By: _____

Dated: _____