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## AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Previous Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_

I request and authorize \_\_\_\_\_ to release healthcare information of the patient named above to:

**The Surgery Group of Los Angeles**  
8635 W. 3rd St. Ste880W  
Los Angeles, CA 90048  
PH: 310-289-1518 FAX: 310-289-1526

This request and authorization applies to:

Healthcare information relating to the following treatment, condition, or dates: \_\_\_\_\_

All healthcare information

Other: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date Signed: \_\_\_\_\_

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.