DONNA RICHEY, M.D., F.A.C.O.G.

4201 TORRANCE BLVD., SUITE 480
TORRANCE, CA 90503
PHONE: 424.337.1800 FAX: 424.337.1801

MEDICAL RECORD RELEASE FORM

Patient's full name: _____ Date of Birth: _____
Please Print

By signing this form I authorize: _____
Name of previous provider

to release my protected, confidential health information to: Dr. Donna Richey

The purpose for this release of information is for direct patient care.

FAX number of previous provider: _____

PHONE number of previous provider: _____

Specific information requested is :

___ Complete medical record

___ Other: _____

_____

Signature: _____
Patient or Patient Representative

Today's Date: _____