

SOUTH ATLANTIC MEDICAL GROUP, INC.

NISSAN KAHEN, MD

-----, MD

MEDICAL RECORDS RELEASE

PHYSICIAN NAME:

FACILITY ADDRESS:

PHONE NUMBER:

FAX NUMBER:

PATIENT'S NAME:

DATE OF BIRTH:

SOCIAL SECURITY NUMBER:

I AUTHORIZE ALL MEDICAL RECORDS TO BE RELEASED TO:

SOUTH ATLANTIC MEDICAL GROUP, Inc. / Nissan Kahen, MD or _____, MD

**5504 Whittier Boulevard
Los Angeles, CA 90022-4104**

PATIENTS SIGNATURE:

TODAYS DATE

WITNESS SIGNATURE:

TODAYS DATE

IF YOU HAVE ANY QUESTIONS, OR THE REQUESTED RECORDS ARE MORE THAN 15 PAGES, PLEASE CONTACT OUR OFFICE AT (323) 725-0167.

THANK YOU
