SKULL BASE INSTITUTE

AUTHORIZATION TO RELEASE MEDICAL RECORDS

If you would like Skull Base Institute to request your medical records on your behalf, please provide us with the physicians'/facilities' contact information and complete this form; Otherwise, please send all required medical records to the address provided in the box below.

Date: _____

I, _____, hereby give my permission to release my medical records in
(full name)
their entirety to the following physician:

Hrayr Shahinian, MD, FACS
c/o Skull Base Institute
8635 W. 3rd Street - Suite 1170W
Los Angeles, California 90048
Tel: 310.691.8888
Fax: 310.691.8877

Thank You,

_____ _____
Patient Signature Date