515 South Drive ● Suite 12
Mountain View ● California ● 94040

Main: (650) 318-3384
Toll Free: 877-ELIT-MED
Fax: (650) 318-5737

ELITE MEDICAL CENTER
PERSONALIZED PRIMARY CARE

Board Certified Internal and Geriatric Medicine Physicians

Medical Records Release Authorization

Patient Name: _____

DOB: ____/____/_____

Phone Number: (_____) _____ - _____

Please release my medical records from:

Name of provider _____

Address: _____

Phone (_____) _____ - _____ Fax(_____) _____ - _____

TO: **Inna Yaskin, D.O.**

Elite Medical Center

515 South Drive, Suite 12, Mountain View, CA 94040

Phone: (650) 318-3384 Fax: (650) 318-5737

Please release all records, including but not limited to, progress notes, operative notes, laboratory test results, diagnostic tests and x-rays.

I HEARBY AUTHORIZE THE RELEASE OF MY MEDICAL RECORDS AS PROVIDED ABOVE

Patient's signature: _____ Date: ___/___/_____