

**REQUEST FOR RELEASE OF MEDICAL RECORDS**

Requested from: \_\_\_\_\_  
Physician Name(s)/Medical Facility

\_\_\_\_\_  
Address

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip

Released to: Tiffany Gorman, MD

221 E Hacienda Ave, Ste B  
Campbell, CA 95008  
Ph 408 376-3350 Fax 408 374-4130

Patient Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_  
Date of Birth: \_\_\_\_\_

SSN: \_\_\_\_\_

Date: \_\_\_\_\_