RON J. BAHAR, M.D.
A MEDICAL CORPORATION
5363 BALBOA BLVD. SUITE 540
ENCINO, CA 91316–2850
PHONE: (818) 905-6600
FAX: (818) 905-6610

Request for Medical Records from Dr. Bahar

To:	Dr. Bahar	Date:	
Attn:	Front Office Staff	Fax:	(818) 905-6610

☐ STAT ☐ URGENT ☐ REGULAR

Patient's Name: _____ **Date of Birth:** _____

I request and authorize Dr. Ron Bahar, M.D.

To release healthcare information of the patient named above to:

Name: _____

Relation to Patient: _____

Method of Delivery: ☐ Fax ☐ Mail ☐ Pick-up in office

_____

_____

Date you need records by: _____

This request and authorization applies to:

☐ Recent Labs
☐ Progress Notes
☐ Imaging ordered by Dr. Bahar
☐ All labs ordered by Dr. Bahar
☐ Endoscopy and Pathology Reports
☐ Other: _____

** Note: All requests are approved by Dr. Bahar before they are sent.*

_____ _____

Signature of parent, patient, or representative Date

_____

Relationship to Patient

OFFICE NOTES: