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

Authorization to Release Healthcare Information

To:		Date:	
Attn:		Fax:	

☐ STAT ☐ URGENT ☐ REGULAR

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

I request and authorize _____

To release healthcare information of the patient named above to:

Ron J. Bahar, M.D.
5363 Balboa Blvd. Suite 540
Encino, CA 91405
Phone: 818-905-6600
Fax: 818-905-6610

(Please send records via fax preferably, or mail)

This request and authorization applies to:

☐ All medical records

☐ Other: _____

_____

_____ _____

Signature of parent, patient, or representative Date

_____

Relationship to Patient