LAUREN CIEL SWERDLOFF MD INCORPORATED
1821 WILSHIRE BLVD. SUITE # 220
SANTA MONICA, CA 90403
(310) 829-5189
FAX: (310) 829-5942

AUTHORIZATION FOR RELEASE OF RECORDS

To:_____
Doctor or Hospital

_____
Address, phone & fax

Please include the complete medical records in your possession, all labs and imaging reports concerning my illness and/or treatment during the period
from_____to:_____

TO: LAUREN SWERDLOFF, MD1821 WILSHIRE BLVD. SUITE # 220, SANTA MONICA, CA, 90402 Tel: (310) 829-5189 FAX: (310) 829-5942

_____
NAME & BIRTH DATE & MR#

_____
SIGNATURE

_____
DATE

_____
RELATIONSHIP TO PATIENT