

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient Name: _____

Date of Birth: _____ **Social Security #:** _____

Address: _____

Telephone: (Day) _____ **(Home):** _____

I hereby authorize _____ **to send photocopies of medical records, imaging studies, and pathologic slides (when available) concerning the above named individual to:**

**Dr. Donald Lamm, M.D.
BCG Oncology
16620 N. 40th St. Suite E
Phoenix, AZ 85032**

Patient Signature

Date