Michelle Kolsi, M.D., Inc.

110 W. Stocker St., Glendale, CA 91202
Ph: 818-244-7237 | Fax: 818-244-6787
info@michellekolsimd.com

RECORDS RELEASE AUTHORIZATION

To: _____
(Doctor / Facility Name)

_____
(Address)

_____
(Address)

_____/_____
(Phone) (Fax)

I HEREBY AUTHORIZE AND REQUEST YOU RELEASE COMPLETE MEDICAL RECORDS TO:

MICHELLE KOLSI, M.D.

110 WEST STOCKER STREET

GLENDALE, CA 91202

PHONE: 818-244-7237 | FAX: 818-244-6787

All medical records in your possession for my child/children (list **Legal** full names and date of birth):

1. _____ DOB _____
2. _____ DOB _____
3. _____ DOB _____

_____ _____
Signature of Parent / Legal Guardian Date

_____ _____
Name of Parent / Guardian Phone Number