Dr. Donna M. Gallik, MD FACC

Cardiology

Cardiac Electrophysiology and Pacemakers

RECORDS RELEASE

Date:____

To:____

Doctor or Hospital

____

Address

I hereby authorize and request you to release:

To:____

Doctor or Hospital

____

Address

The complete medical records in your possession, concerning my illness and/or treatment during the period:

From:_________________________________To:____________________________

Signed:____

(Patient or nearest relative)

Print Name:____

Witness:____

Los Angeles Location	Antelope Valley location
8631 West Third Street, Suite 1017E Los Angeles, CA 90048 Phone: 310-289-5901	43847 Heaton Ave, Suite I Lancaster CA 93534 Phone: 661-974-1607