**Tien Vo M.D., Inc.**

**Family, Internal & Cosmetic Services**

1590 SOUTH IMPERIAL AVE

El Centro, CA 92243

Phone: (760) 352-2551

Fax: (760) 352-3022

**RELEASE OF RECORD**

**TO DR:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**I UNDERSTAND MY MEDICAL RECORDS MAY CONTAIN INFORMATION REGARING THE DIAGNOSIS OR TREATMENT FOR HIV (AIDS VIRUS), OTHER SEXUALLY TRANSMITTED DISEASES, DRUG AND/OR ALCOHOL ABUSE, MENTAL ILLNESSES OR PSYCHIATRIC TREATMENT. I GIVE MY SPECIFIC AUTHORIZATION FOR THE RECORDS TO BE RELEASED TO:**

**DR. TIEN VO**

**1590 SOUTH IMPERIAL AVE**

**EL CENTRO, CA 92243**

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**Patient's Name (Please print clearly) Date of Birth**

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**Patient's Signature Date Signed**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Witness**

**NOTE: Please release patient's records, to include but not limited: progress notes, labs reports, radiology reports, EKGs and pertinent data within the last 6 (six)months from date of request.**