Authorize Carmen Roman, M.D. to Release Confidential Information

Complete form in black ink. Sign and return to Carmen Roman, M.D. by mail or fax.

From:

Name: _____

Address: _____

Address: _____

City: _____ State: ____ Zip: _____

Telephone: (_____) _____-_____ Fax: (_____) _____-_____

To:

Carmen Roman, M.D.
611 Veterans Boulevard, Suite 217
Redwood City, CA 94063

Fax: (650) 260-2953
Tel: (650) 465-3129

I hereby authorize Carmen Roman, M.D. to release confidential information to and discuss my case personally with:

Person/Organization: _____

Address: _____

Address: _____

City: _____ State: ____ Zip: _____

Telephone: (_____) _____-_____ Fax: (_____) _____-_____

Signature: _____ Date: ____/____/_____