St. Joseph Health
St. Joseph Hospital
The Center for
Cancer Prevention and Treatment
A member of the St. Joseph Hoag Health alliance

RECORD RELEASE AUTHORIZATION

TO _____
DOCTOR OR HOSPITAL

I HEREBY AUTHORIZE AND REQUEST YOU TO RELEASE TO:

- ☐ KRISHNANSU S. TEWARI, MD
- ☐ FABIO CAPPUCCINI, MD
- ☐ _____

GYNECOLOGIC ONCOLOGY PROGRAM
1000 WEST LA VETA AVENUE
ORANGE, CA 92868

TELEPHONE: 714-734-6294
FAX: 714-734-6231

THE COMPLETE RECORDS IN YOUR POSSESSION CONCERNING MY ILLNESS AND/OR TREATMENT:

_____ FOR THE PERIOD FROM _____ TO _____

_____ ALL RECORDS

NAME _____ DATE OF BIRTH_____

ADDRESS _____

PHONE NUMBER(S) _____

AUTHORIZED SIGNATURE _____ DATE _____