

NENA FLOR CAMBARE-PIGA, M. D.

NAOMI C. PIGA, M.D.

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REQUEST FOR RELEASE OF MEDICAL RECORDS

PATIENT'S NAME/S: _____

DATE/s OF BIRTH : _____

T O: _____

(Name of Physician)

Address (Street & City)

(State & Zip Code)

Tel. No.

Fax No.

This is to authorize your office to release to Dr. Nena Flor Cambare-Piga a copy of medical records of the patient/s named above.

Requested by:

Parent's/Guardian's Signature

Date