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

To: _____

_____

_____

I hereby authorize you to release to:

Carmen Roman, M.D.

611 Veterans Boulevard, Suite 217
Redwood City, CA 94063

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

confidential information about my case concerning the following:

_____

and to discuss the matter personally with her.

First Name: _____Last Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: (_____) _____ - _____

Signature: _____Date: ____/____/_____