# Medical Record Release

Release records from: _____

Child's Name: _____

Date of Birth: _____

Child's Name: _____

Date of Birth: _____

Child's Name: _____

Date of Birth: _____

**Please mail _____ complete or _____ summary of records to:**

Marina Yam , M.D.
825 POLLARD RD, #109
LOS GATOS, CA 95032

***I authorize as parent or guardian of above child the release of records.***

Parent's signature _____ Date: _____