**BRIGID FREYNE M.D.**
39755 MURRIETA HOT SPRINGS RD.
SUITE F110
MURRIETA CA, 92563
(951) 696-4600
(951) 696-4601

----------CONSENT FOR RELEASE OF RECORDS----------

I Hereby Authorize (Physician Or Hospital)
Name & Address:

_____

_____

_____

To Release All Medical Records, X-rays And Labs In Your Possession Concerning:

Name:

_____

Date Of Birth:

_____

To:

BRIGID FREYNE M.D.
39755 MURRIETA HOT SPRINGS RD.
SUITE F110
MURRIETA CA, 92563

This Release Is Limited For The Purpose Of Contuinued Medical Care Of Said Patient. This Authorization Shall Remain In Effect For Three Months From The Date Below. I Understand That The Requester May Not Futher Use Or Disclose This Medical Information Unless Another Authorization Is Obtained By Myself, Unless Permitted By Law. I Also Understand That I Have A Right To Recieve Copies Of My Medical Records Upon Request.

_____

Signature Of Patient Or Guardian Date

_____

Witness Date