TORRANCE MEMORIAL | An Affiliate of Cedars Sinai

MEDICAL STAFF OFFICE AUTHORIZATION FOR RELEASE OF INFORMATION

I,_____, hereby consent to the release by TORRANCE MEMORIAL MEDICAL CENTER, of **proctoring reports**. I hereby release TORRANCE MEMORIAL MEDICAL CENTER and all representatives, agents, attorneys and officers thereof for their acts performed in connection with this release of such information.

PROCTORING REPORTS TO BE SENT TO: _____
(NAME OF HOSPITAL)

NAME OF RECEIVING PERSON:_____

PHONE NUMBER OF HOSPTIAL (RECEIVING PERSON: _____

FAX NUMBER OF HOSPITAL (RECEIVING PERSON):_____

EMAIL ADDRESS OF RECEIVING PERSON: _____

_____
Physician Name (Please Print)

_____
Physician Signature

_____
Date

PLEASE EMAIL THE COMPLETED FORM TO: Toni.Woodard@tmmc.com
THE MEDICAL STAFF OFFICE
3330 Lomita Boulevard • Torrance, CA 90505-5073 • 310-517-4616 Phone