TORRANCE MEMORIAL MEDICAL CENTER

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.

FAX PROCTORING REPORTS TO: _____
(NAME OF HOSPITAL)

FAX NUMBER OF HOSPITAL:_____

_____
Physician Name (Please Print)

_____
Physician Signature

_____
Date

FAX COMPLETED FORM TO TMMC MEDICAL STAFF OFFICE: (310) 784-8777

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