Authorization to Release Medical Information

Los Gatos
408.884.1972
14127 Capri Drive, Suite 5A , CA 95032

WHOLE medicine

To: _____

Name of doctor, clinic or hospital, etc.

Address: _____

Address of doctor, clinic or hospital, etc.

I, _____

Client's name

request the following information:

☐ X-rays ☐ History ☐ Records ☐ Diagnosis ☐ Treatment ☐ Reports
☐ Billings

concerning my:

○ Accident ○ Injury ○ Illness ○ Other: _____

To be released to: _____

Name of insurance company, attorney, doctor, clinic or hospital, etc.

Address: _____

Name of insurance company, attorney, doctor, clinic or hospital, etc.

For the purpose of: _____

Specify the purpose of the request.

According to Section 25252 of the California Health and Safety Code, these records must be provided within 15 days of receipt of this notice.

Representative Name: _____

Representative Signature: _____ Date: _____