Authorization to Release Medical Records

This authorization is signed voluntarily and is to be used as a release of x-rays, laboratory results, examination findings, and health information for the evaluation of a condition, for the purpose of treatment. No information will be sent out without the receipt of a signed authorization form from the party, i.e: lawyer, insurance carrier. At any time, you may revoke this authorization in writing and have any information removed from your health file. A copy of this signed authorization will be kept in your file and may be copied at any time.

I hereby authorize ____(facility)

Address: ____

Phone: ___________________________Fax No: ____________________

To release the medical records of:

Patients Name: ____

Address: ____

Phone: ___________________________Date of Birth:________________

To:

San Pedro Acupuncture
@ Vital Health
660 W 7th Street
San Pedro, CA 90731
Office: (310) 832-4476
Fax: (310) 832-7034

☑ most recent blood work and lab results

☐ Imaging and/or imaging reports

☐ Other (describe): ____

I understand that these records are protected under federal and/or state laws and cannot be disclosed without my written consent unless otherwise provided by law.

By my signature below, I hereby, knowingly and voluntarily, authorize San Pedro Acupuncture & Dr Jennifer Randolph, DACM, L.Ac. to request my health information.

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Signature of Patient Date