JUSTIN EHRLICH
Integrative Chinese Medicine

CONFIDENTIAL

REQUEST FOR MEDICAL RECORDS

Patient Name:_____ DOB:_____

By signing this form, I authorize:

Name
(Doctor):_____

Address:_____

City_____ State:_____ Zip Code: _____

Phone: _____ Fax: _____

To release confidential health information about me, by releasing my medical records to:

Justin Ehrlich, L.Ac.
4443 30th Street, Suite 210
San Diego, CA 92116
Tel: 619.535.1876

The information you may release subject to this signed release form is as follows:

☐ Entire Chart ☐ Treatment Notes ☐ Laboratory Reports ☐ Pathology Reports ☐ Radiology Reports

☐ Surgical Reports ☐ Other _____

_____ _____
Printed Name of Patient/Representative *Signature of Patient/Representative*

_____ _____
Date *Relationship to Patient*

THANK YOU FOR YOUR PROMPT ATTENTION TO THIS MATTER!!