LA Herbs & Acupuncture

Wellness through ancient wisdom

Request/Consent to Release Records & Information
CONFIDENTIAL

I, _____(print full name), born on _____,

Address _____, Phone _____.

hereby authorize:
Person or Facility _____

Address _____

Tel. _____ Fax _____

To Disclose To:
LA Herbs & Acupuncture
2990 S. Sepulveda Blvd. #205
Los Angeles, CA 90064
Tel (310) 598-5209 Fax (310) 492-5185 Secure Email: info@laherbsandacupuncture.com

The Following Information:
_____ Initial Medical Assessment _____ Drug Screens _____ Lab Results _____ Progress Notes

_____ Intake & Discharge Summaries _____ Treatment/Discharge Plan _____ Progress in Treatment

_____ Mental Health Evaluation/History _____ Complete Medical Record to Date

_____ Other _____

For the purpose of:
Medical Treatment Planning & Coordination

Information to be released via: _____ Fax _____ Email _____ Photocopy/Mail _____ Telephone

I understand the purpose of this request/authorization to release records and information, including the nature of the records, their contents, and the consequences and implication of their release. This request is entirely voluntary on my part. I am aware that I may take back this consent at any time within 90 days, except to the extent that action based on this consent has already been taken. This consent will expire automatically after 90 days from the date on which it is signed, or upon fulfillment of the purposes stated above.

_____ _____ _____
Print Patient or Patient/Guardian Name Patient or Patient/Guardian Signature Date