Date: _____

To: Women's Integrative Health
477 N. El Camino Real, Suite C304
Encinitas, CA 92024
Fax: (760) 942-7163

Please release of a copy of my medical records to:

Name:_____

Address: _____

_____

_____

Phone: _____

Regarding: _____Results or
_____All History, including: _____ psychiatric information,
_____sexually transmitted disease information (including HIV),
_____substance abuse information and _____physical or sexual abuse information.

Date of Birth: _____

Patient Name: _____

X Patient: _____
Signature for release of information

If you have any questions please contact me immediately at:

_____