acupuncture center
of la jolla

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I, ______________________________ hereby authorize Acupuncture Center of La Jolla to obtain medical information from my physician's office, hospital or other institution or person having similar information or knowledge of my health condition in order to examine health related information. This document and all of its contents are held strictly confidential and are used for examining health related information only.

I agree that this authorization is valid for (2) months from the date thereof, during which time I may retract this request, verbally or in writing, and that a photocopy or facsimile of this document is as valid as the original. The Acupuncture Center of La Jolla may receive telephonic and/or written verification from the requesting establishment.

By signing your name you agree that you have read and understood all of the information on this document and its intended uses.

Name ____ Birthdate _____/____/_____

Address ____ SS# ______-_____-______

____ Phone (   ) _____-_______

____ ____________________

Signature Date

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