AUTHORIZATION
FOR RELEASE OF HEALTH INFORMATION

I authorize _____ to release health
(name of person or facility which has information)

information to: **David Wolff, M.D**.
9009 Beverly Blvd. Suite 105
LOS ANGELES, CA 90048
telephone (310) 273-5689 fax (310) 273-4587
email: dr@davidwolffmd.com

TYPE OF RECORDS: _____Medical
_____Mental Health (other than psychotherapy notes)

TYPE OF INFORMATION TO BE RELEASED:

DATE OR TIME PERIOD FOR REQUESTED INFORMATION:

EXPIRATION OF AUTHORIZATION
Unless otherwise revoked, this authorization expires upon written notification

MY RIGHTS
1) I may revoke this authorization at any time
2) I am entitled to receive a copy of this authorization

SIGNATURE _____ _____
signature of patient or patient's legal representative telephone no.

_____ _____
printed name date