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.**
9201 SUNSET BLVD. SUITE 606
LOS ANGELES, CA 90069
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