



Elisa Song, MD | Donna Ruiz, MD | Suruchi Chandra, MD | Christina Peretz, MD | Kandice Stellmon, NC

## Authorization to Release Medical Information To Whole Family Wellness

**Attention:**

Doctor / Hospital: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Tel #: \_\_\_\_\_ Fax #: \_\_\_\_\_

Re: Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Tel #: \_\_\_\_\_ Fax #: \_\_\_\_\_

I hereby authorize and request you to release all health care information for the patient named above, including all clinic notes, hospital summaries, lab work and diagnostic workup that has been performed to:

**Whole Family Wellness**  
1601 El Camino Real, Suite 101  
Belmont, CA 94002  
T: 650-595-5437  
F: 650-595-5438  
E-mail: [info@wholefamilywellness.com](mailto:info@wholefamilywellness.com)

I understand that I have a right to receive a copy of this authorization upon request. I also understand that this authorization may be modified or rescinded but that such rescission or modification will only be effective when delivered in writing.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed name of legally authorized individual: \_\_\_\_\_

Relation to patient: \_\_\_\_\_