Medical Records Request and Release

Patient Name: Date of Birth:

I, the undersigned, hereby authorize:

Doctor/Clinic Name: _____

Office Address: _____

_____

Telephone: _____

FAX: _____

To provide from my medical record the information specified below to:

Kevin Uchida, LAc.
c/o Uchida Acupuncture
5839 Green Valley Circle, Suite 201
Culver City, CA 90230
Tel: 424-543-6775
FAX: 424-543-6776

Release the following information:

Release or transfer of the specified information to any person or entity not specified herein is prohibited and additional written consent must be obtained for a proposed new use of the information or for its transfer to another person or entity.

Authorization shall be valid until six months from the date listed on this document. I understand that I have a right to receive a copy of this authorization upon my request. The Health and Safety Code mandates that the receiving physician or office fulfill this request in a timely manner.

Patient Signature: _____ Today's Date: _____