INTEGRATIVE PEDIATRIC WELLNESS CENTER

Dr. Edmond Sarraf

955 Carrillo Dr. Suite 210

Los Angeles CA 90048

Ph (310)888-7778

Medical Records Release

Patient Name & Date of Birth:

_____

_____

_____

I, _____ authorize: _____

Parent/ Legal Guardian — Physician name

_____

Phone number & Fax number

Send the following records:

____ All Medical Record

____Immunization Record only

____Lab Reports

To:

Dr. Edmond Sarraf

955 Carrillo Dr. Suite 210

Los Angeles CA 90048

Fax: (310) 888-7732

I understand that this authorization:

1. Authorization expires one year from the date signed.
2. I may revoke this authorization at any time.
3. I understand a fee may be charged for duplication of records.
4. I may request a copy of this authorization.

_____ _____

Signature of Parent or Legal Guardian — Date