

Dr. Steven Ross

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"Creating Better Health for the Rest of Your Life"

Authorization for Release of Medical Information

To: (Provider) _____
(Name of Doctor, Clinic, Hospital, etc.)

Address: _____

Patient name _____

Date of Birth _____ Soc. Sec. # _____

I, _____ request the following information:

- Test results History Records Diagnosis
- Treatment Reports Progress

concerning my: Accident Injury Illness

Other _____

To be released to: Dr. Steven Ross, Ross Health and Wellness

**Address: 3525 Del Mar Heights Road, Suite 909
San Diego, CA 92130**

Phone: 858-481-1131, Fax:858-433-0508

For the purpose of: evaluation and assessment of treatment.

According to Section 1795 of the California Health and Safety Code, these records must be provided within 15 days of receipt o this notice.

Signed: _____ Date: _____

- Patient Spouse Parent Guardian