Medical Release Request

Patient name ____ Date of Birth _____/_____/_____

SSN _________________________ Address _____________________________________ City ________________

State ______ Zip Code _________ Phone (   ) _______________ Email ___________________________________

Information requested from:

Providers name ____ Fax (   ) _______________________

Phone (   ) __________________ Email ____

Send information to:

Stacy L. Waneka, M.D.
Phone 310-270-3808
Fax 818-338-1498
stacy@drwaneka.com

I, ___________________________________, hereby grant permission for you to release confidential health information about me, by releasing a copy of my medical record, a summary or narrative of my protected health information, or a verbal report to the physician entity.

____ ____________________

Printed name Date

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Signature of patient (or responsible party)