IDEAL BODY CENTER

6150 Horseshoe Bar Rd
Loomis, CA 95650

REQUEST FOR MEDICAL RECORDS

Date: ____________________

Patient's Name: ____

DOB: _____________________

I, ____, am providing written authorization for the following provider to release my medical records to The Lovell Center (address and fax number listed above).

Name and Address of Provider/Facility to Release Records to Ideal Body Center

____

This authorization includes the release of the following checked records:

___ Lab Reports
___ Test Results
___ Demographics
___ Prognosis
___ Progress Notes
___ Consultations

___ All of the Above

___ Other: ____

____
Signature of Patient or Authorized Representative

____
Printed Name of Patient

____
Witness

____
Date

This fax contains medical information which is considered confidential, personal and privileged.

It is intended for the above-named recipient only.
If you have received this fax in error, please destroy it and call us to let us know that you received it.
Thank you.