AUTHORIZATION TO RELEASE MEDICAL INFORMATION

To:_____

Address:_____Telephone_____

Please release the following information to:

Pro-Active Health Center
4125 Market Street, Suite 6
Ventura, California 93003
Tel: (805) 650-0495
Fax: (805) 650-0434

____X-Rays ____History ____Records ____Diagnosis

____Treatment ____Reports

Patient Name_____

Signed_____Date_____

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