

**Pro Health Group, Inc.**  
**Patient Consent to Release Medical Information**

This form allows other medical providers to release your medical information to Pro Health Group, Inc. in the event you require us to have your historical medical information.

Patient Name: \_\_\_\_\_

Other Names Used: \_\_\_\_\_

Patient Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ (MM/DD/YYYY)

Social Security Number: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Medical Record Number: \_\_\_\_\_

I HEREBY AUTHORIZE THE RELEASE OF ANY AND ALL MEDICAL RECORDS OBTAINED IN THE COURSE OF MY DIAGNOSIS AND TREATMENT INCLUDING SUMMARIES, LABORATORY AND DIAGNOSTIC STUDIES, MEDICATIONS AND IMMUNIZATIONS TO:

**PRO HEALTH GROUP, INC.**  
**DR. ERICA LEHMAN**  
**125 NORTH ROBERTSON BLVD**  
**BEVERLY HILLS, CA 90211**  
**ATTN: MEDICAL RECORDS**  
**TEL: (310) 504-3700**  
**FAX: (310) 919-1199**

A COPY OF THIS RELEASE IS AS EFFECTIVE AS THE ORIGINAL

Print Patient Name \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

**\*\*\*If patient is a minor, all legal guardians must sign below**

Print Guardian Name \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

Indicate relationship if signing for patient \_\_\_\_\_

Print Guardian Name \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

Indicate relationship if signing for patient \_\_\_\_\_

Print Guardian Name \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

Indicate relationship if signing for patient \_\_\_\_\_