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_____