

Request for Medical Records

Date: _____

I, _____ Hereby request a copy of my
medical records as stated below:

RELEASE RECORDS FROM:

- Release all medical records
 Release Medical Records as stated:

Release Records to: Kushner Wellness Center
11480 Brookshire Ave #200
Downey, CA 90241
(562) 528-9792 Fax: (847) 241-8424

Patient Signature: _____

Patient Name: _____

Date of Birth: _____ Relationship: _____

