



Women's Integrative Health

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Date: _____

To: _____

I authorize release of a copy of my medical records to:

Women's Integrative Health
477 N. El Camino Real, Suite C304
Encinitas, CA 92024
FAX: (760) 942-7163

Regarding:

Date of Birth: _____

Patient Name: _____

X Patient: _____

Signature for release of information