Dr. Elvira Lindwall
Phone: (805) 370-1965 2190 Lynn Rd. Suite 240
Fax: (805) 370–1984 Thousand Oaks, CA 91360

CONSENT TO RELEASE MEDICAL RECORDS

Patient name: _____Home Number: _____

Date of birth: _____Cell Number: _____

I hereby authorize and request that _____
Name of facility/individual

_____
Address City/State/Zip

Release information from my records to the following:

Name of the Facility/individual: _Dr. Elvira Lindwall _____ Fax Number, if applicable _(805) 370-1984_

___2190 Lynn Rd. Suite 240 Thousand Oaks, CA 91360_____
Address City/State/Zip

Please be specific regarding record and dates requested information to be released

- ☐ Diagnosis and record of treatment _____
  Specific date / dates requested
- ☐ Laboratory and/or X-ray reports _____
  Specific date / dates requested
- ☐ Entire file (excluding confidential and psychiatric records, if any)
- ☐ Other _____

BE ADVISED THAT IF YOU ARE REQUESTING A COPY OF YOUR MEDICAL RECORD, A COPYING FEE MAY APPLY. IT IS PROHIBITED BY LAW TO RELEASE/DISCLOSE THE ATTACHED/ENCLOSED INFORMATION TO ANYONE EXCEPT THOSE SPECIFIED ABOVE. I UNDERSTAND THAT THIS AUTHORIZATION ALONE MAY NOT AUTHORIZE RELEASE OF PSYCHIATRIC OR HIV INFORMATION.

▶ In signing, I am aware that this Authorization is valid for 30 calendar days after today.

▶ Signature:_____ Date: _____

If a minor; signature, name and date of parent/guardian: Signature: _____

Date: _____ Name: _____