Reed S. Wilson, M.D.
435 N. Roxbury Dr., Suite #300
Beverly Hills, CA 90210

Consent For Release of Medical Records:

Patient Name:
Patient Street Address:
Patient City, State and Zip:
Patient Social Security Number:
Patient Date of Birth:

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the person(s) or entity listed below.

Please release my protected medical information to:

Reed S. Wilson, M.D., Inc.
435 N. Roxbury Dr., Suite #300
Beverly Hills, CA 90210

Patient Signature:________________________________
Date: ___________________

Legal Guardian or Patient Representative:_____________________________________
Date: ___________________