Ventura Center for
Advanced Therapeutics

PATIENT REFERRAL

Patient Name: ______________________ Date of Birth: ______________

Patient Diagnosis/Reason for Referral:

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Referring Provider: ______________________________

Address: ______________________________

Phone: ______________________ Fax: ______________________

Email: ______________________________

AUTHORIZATION FOR RELEASE OF INFORMATION

In the course of my examination, I, ______________________ herby give authorization for Stefany D. Wolfsohn, M.D. to

☐ RELEASE MY RECORDS TO: ______________________

☐ OBTAIN MY RECORDS FROM: ______________________

______________________ ______________

Patient's Signature Date

PLEASE COMPLETE AND RETURN TO EMAIL OR FAX BELOW