



Patient's name (print) _____
Last First Middle

Patient's signature _____

Patient's date of birth _____

Date of Request _____ Date Mailed/Picked Up _____

I authorize the release of my medical records, as listed below, to/from:

- Alexandra R. Bunyak, M.D.
- Keenan S. Carriero, D.P.M.
- Amy L. Dusenberry, PA-C
- Justin G. Ehrlich, L.Ac
- Robert I. Gelb, M.D.
- James K. Gillan, PA-C
- Kiersten L. Gregory, PA-C
- Raymond J. Linovitz, M.D.
- Gregory J. Loren, M.D.
- Timothy A. Peppers, M.D.
- Lex A. Simpson, M.D.
- Michael J. Skyhar, M.D.
- L. Erik Westerlund, M.D.

I will pick up records on _____

(Note: Please pick up medical records on the due date or they will be destroyed)

- MRI's*
- Records*
- X-rays*
- Records, X-Rays and/or MRI's*

Please send these records to:

Doctor's name _____

Address _____

CORE Orthopaedic Medical Center
Attn: Medical Records
332 Santa Fe Drive, Suite 110
Encinitas, CA 92024