



Whole Health Associates
Center for Integrative Medicine
880 Las Gallinas Ave, Suite 1
San Rafael, CA 94903
Phone: 415-492-9355
Fax: 415-492-9350

To: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

Please provide the following requested information to:

- Stacy Bischoff, RN, NP**
- Stephen Zilber, LAc**
- Martin Borge, DC**
- Grace Pike, BPHE, DC**
- Tuyet Cong-Ton-Nu CNC**
- Donna Marie Scippa, RN, NP, CTT**

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Dates of service from _____ to _____

- | | |
|------------------------------------------------------------|-----------------------------------------------|
| <input type="checkbox"/> All Pertinent Medical Information | <input type="checkbox"/> Consultation Reports |
| <input type="checkbox"/> Diagnosis, Problem List | <input type="checkbox"/> Operation Reports |
| <input type="checkbox"/> History, Physical, Progress Notes | <input type="checkbox"/> Pathology Reports |
| <input type="checkbox"/> Medication Lists | <input type="checkbox"/> Laboratory Reports |
| <input type="checkbox"/> X-Ray Reports | |

I give my permission for the above practitioner to speak to _____ regarding my medical and /or psychiatric condition.

Patient's Name: _____ D.O.B. _____

Patient's Signature: _____ Date Signed: _____

Kaiser Number: _____

Witness: _____