nalini chilkov L.Ac., O.M.D.
DOCTOR OF ORIENTAL MEDICINE

CONFIDENTIAL

REQUEST FOR RECORDS

Date:______________________________

Doctor:____

Address:____ Suite:_______________

City:________________________State:________________ZipCode:____________________

I authorize you to furnish the following information regarding my condition, history, findings and diagnosis. Please send copies today:

By Mail
Nalini Chilkov, O.M.D.
2632 Wilshire Blvd. Suite 496
Santa Monica, CA 90403
310-453-5700

By Fax
424-280-3014

OR

By Email (PDF)
patients@healthtools.com

Please send records for the period____

Laboratory Reports   Pathology Reports   Radiology Reports

Surgical Reports   Treatment Notes   Other:______________________________

____
Patient Name

____
Patient Signature (Parent if Patient is a Minor)

____
Date of Birth

____
Social Security Number

____
Address

____
Phone

____
City   State   Zip Code

____
Fax

Thank you for your prompt attention to this matter!!!