

MEDICAL RECORDS REQUEST

Peter J. Knoblich, M.D. · Optimal Weight and Wellness Medical Centers
Optional when requesting your own records; a written email or letter is also acceptable.

1. PATIENT INFORMATION

Patient's full legal name

Date of birth

Phone

Email address

Current mailing address

2. WHAT ARE YOU REQUESTING?

☐ A copy of my records for my own use

☐ Send records to another provider/person (complete Pages 2–4)

☐ Other request _____

3. WHICH RECORDS?

☐ Complete available medical record

☐ Medication list

☐ Other

Date range, if applicable: from

through

4. DELIVERY PREFERENCE

☐ Secure electronic link to my email above

☐ Paper copies mailed to my address above

5. PATIENT / REPRESENTATIVE CERTIFICATION

I certify the information above is accurate and that I am the patient or am authorized to act for the patient.

Patient/representative signature (type name if submitting electronically)

Date

If representative: printed name

Relationship and legal authority

6. RETURNING YOUR REQUEST

Email: owwc.roseville@gmail.com

Before Dec. 31, 2026: Peter J. Knoblich, M.D., Optimal Weight and Wellness Medical Centers,
512 Royer Street, Roseville, CA 95678

After Dec. 31, 2026: Peter J. Knoblich, M.D., and Darla Jo Mabery, D.O.,
P.O. Box 6625, Auburn, CA 95604-6625

Digital copies of existing medical records will be provided without a processing fee.

Paper copies will be subject to a copy/print fee and postage if mailed.

Do not leave records requests in voicemail. Email or mail your written request.

AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION

Complete Pages 2–4 only if you want records sent to another person or provider.

I authorize the following provider to disclose my medical information:

Peter J. Knoblich, M.D., records custodian

Optimal Weight and Wellness Medical Centers

Information authorized for disclosure

The records selected and described on Page 3, including medical, psychiatric medication-management, laboratory, and weight-management records maintained by the practice, for the date range specified on Page 3.

Recipient

The person or organization identified on Page 3.

Purpose and limitation on use

Continuity of care or the other purpose specified on Page 3. The recipient may use the information only for that purpose, subject to applicable law.

Expiration

This authorization expires one year after the date I sign it, unless I specify an earlier expiration date on Page 3.

I understand that I may receive a copy of this signed authorization.

I have been advised of my right to receive a copy and how to request another copy or digital version from the practice.

AUTHORIZATION DETAILS

Patient's full legal name

Date of birth

Person or provider authorized to receive records

Practice / organization

Recipient mailing address

Recipient phone

Fax

Email / secure delivery address

Records to disclose (check all that apply)

☐ Complete available medical record

☐ Medication list

☐ Specific exclusions:

List records you do NOT want released: otherwise write "None."

Date range: from _____ through _____

AUTHORIZATION — PURPOSE, RIGHTS & SIGNATURE

Purpose (check one and complete if needed)

☐ Continuity of care

☐ Other purpose

Earlier expiration date (optional)

I may revoke this authorization in writing at any time, except to the extent action has already been taken in reliance on it. Send revocation to the practice at the mailing address on Page 1.
Information disclosed may be redisclosed and may no longer be protected by federal privacy law.

My treatment, payment, health plan enrollment, or eligibility for benefits will not be conditioned on signing this authorization, except as permitted by law.

Patient signature (type name if submitting electronically) Date signed

If signed by a representative, provide name and legal authority:

Representative name

Authority

Signatures on this page execute only the authorization to disclose medical information.