



Doctor's Notes: \_\_\_\_\_  
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\_\_\_\_\_

I have examined the patient and refer him/her to Dr. Carlos Gonzalez at LA Health & Rejuvenation. I understand that, upon referral, the supervising Physician will assume responsibility for the patient as it pertains to the care that he/she provides. The patient understands that all further tests and subsequent care will be provided by Dr. Carlos Gonzalez at LA Health & Rejuvenation.

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Physician's printed name

\_\_\_\_\_  
Physician's Telephone Number

\_\_\_\_\_  
Physician's e-mail address

**Please fax the completed and signed exam form to 954-919-9370**

