PO Box 408, Bradford, RI 02808
Phone: (401) 348-2800 | Fax: (401) 377-2343
www.mmwellnesscenter.org

Authorization to Release or Request Protected Health Information

Last Name: ______________________ **First Name:** ________________________ **DOB:** ____/____/____

Home Address: ____

Cell Phone: ________________________________ **Email:** ______________________________________

I hereby give M+M Wellness Center authorization to (specify):

☐ **Release Information to:** ☐ **Obtain Information from:** ☐ **Discuss Information with:**

A. Company/Individual Name: ____
Phone: ___________________________ Fax: _________________________________

B. Company/Individual Name: ____
Phone: ___________________________ Fax: _________________________________

C. Company/Individual Name: ____
Phone: ___________________________ Fax: _________________________________

Covering the period of treatment from: _______ **to** ______ **OR** ☐ **ALL**

Phone Conversation	Dates of Service	Billing Information	Clinical Notes	Labs/ Medications	Other:

I authorize M+M Wellness Center to release and/or obtain confidential information in both written and spoken form to the person(s) noted above. I freely and knowingly consent to waive any rights I may have to confidentially of communications and records for the above stated person. I understand I may revoke this consent to release information in writing at any time. When requesting your records from M+M Wellness Center, please allow a 15-day window for records to be completed. Copying fee: $1.00 per page. Processing Fee: $25 if records exceed 10 pages. Postage fees, if mailed: TBD

____

Printed Name of Patient or Authorized Representative **Date:** ____/____/____

____

Signature of Patient or Authorized Representative