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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, Inc 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

Table with 6 columns: Phone Conversation/Email, 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 confidentiality 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: \$1.50 per page. Processing Fee: \$50. Postage fees, if mailed: TBD

Printed Name of Patient or Authorized Representative

Date: / /

Signature of Patient or Authorized Representative