M + M WELLNESS CENTER

PO Box 2415, Glen Allen, VA 23060
Phone: (804) 302-8164 Fax: (804) 302-8165
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**

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 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: $1.50 per page. Processing Fee: $50. Postage fees, if mailed: TBD

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

Signature of Patient or Authorized Representative