whole family wellness

Authorization to Release Medical Information
To Whole Family Wellness

Attention:

Doctor / Hospital: _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Tel #: _____ **Fax #:** _____

Re: **Patient Name:** _____ **DOB:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Tel #: _____ **Fax #:** _____

I hereby authorize and request you to release all health care information for the patient named above, including all clinic notes, hospital summaries, lab work and diagnostic workup that has been performed to:

Whole Family Wellness
1601 El Camino Real, Suite 101
Belmont, CA 94002
T: 650-595-5437
F: 650-595-5438
E-mail: info@wholefamilywellness.org

I understand that I have a right to receive a copy of this authorization upon request. I also understand that this authorization may be modified or rescinded but that such rescission or modification will only be effective when delivered in writing.

Signature: _____ **Date:** _____

Printed name of legally authorized individual: _____

Relation to patient: _____