



AUTHORIZATION TO RELEASE INFORMATION FORM

PATIENT INFORMATION

Name: _____ **Date of birth:** _____

Address: _____

Phone: _____ **Email:** _____

HEALTHCARE PROVIDER INFORMATION

I, _____, authorize the following entity to release my information:

Name/organization: _____

Address: _____

Phone: _____ **Email:** _____

RECIPIENT INFORMATION

I, _____, authorize the release of my information to:

Name/organization: Integrative Medicine & Wellness Center

Address: 7900 Sudley Rd, Ste 416, Manassas, VA 20109, US

Phone: +1 (703) 563-3804 **Fax:** +1 (866) 611-2705

Email: IntegrativeMWcenter@gmail.com

The information to be released includes discharge summary, laboratory test results, nurse notes, entire medical record, physician's orders, X-ray report, pathology report, progress notes, history and physical report, other (please specify): _____

Expiration of authorization: _____

ACKNOWLEDGEMENT

I have read and understand the terms of this authorization. By signing below, I authorize the release of my information as specified above.

Name: _____ **Date:** _____

Signature: _____