Personal Information

Client Contact Information

First name

Last name

Phone Number

Email

Birth date

month

day

year

Street address

City

State

Zip code

Authorization

I hereby authorize the release of any and all pertinent health and medical information including diagnoses, tests, labs, reports, prescriptions, procedures, and notes. This release of information will remain in effect until terminated by me in writing.

Facility/ Name authorized to RELEASE information.

Facility/ Name authorized to RECEIVE information.

Please check each box to verify that by signing this authorization you understand:

- [ ] I have the right to receive a copy of this authorization
- [ ] I authorize the disclosure of my identifiable health information as described above.
- [ ] I have the right to terminate this authorization and revoke permission to release information. The revocation must be made in writing and will not affect information that has already been disclosed
- [ ] I understand that the person to whom my medical information is disclosed pursuant to this agreement may not further use or disclose the information unless another authorization is obtained from me or unless such disclosure is required by law.
- [ ] I am signing this authorization voluntarily.

Send Medical Records

Send Information to InHabit Wellness

Send Information to other facility listed.

Other Facility Mailing Address, Email, Fax or Phone Number.

Signature

Date