Restorative Health & Wellness

MEDICAL INFORMATION RELEASE FORM

Please write or print clearly. Your information will remain confidential between you and your Health Coach.

Patient Name_____ Date of Birth _____

SSN _____ Address _____ City _____

State_____Zip Code_____ Phone ( )_____ Email _____

INFORMATION REQUESTED FROM:

Name _____

Address _____ City _____ State _____

Zip Code _____Phone ( ) _____Fax ( )_____

Email _____

SEND INFORMATION TO:

Name _____ Send by: ___Mail ___ Fax ___ Secured Email

Address _____ City _____ State _____

Zip Code _____ Phone ( ) _____ Fax ( )_____

Email _____

Restorative Health & Wellness

I,_____(*Name*), herby grant permission for you to release confidential health information about me, by releasing a copy of my medical record, or a summary or narrative of my protected health information, to the physician / person/ facility/ entity

Printed Name _____ Date _____

Signature _____ Date _____