CONSENT FOR RELEASE OF MEDICAL RECORDS

I do hereby consent and authorize you to release copies of my medical records, including current and previous medical records from other practices and practitioners, hospitals, and/or clinics, which are a part of my medical records. PLEASE NOTE: This authorization includes consent for the release of alcohol, drug, psychiatric and psychological information and any information relating to pregnancy, sexually transmitted diseases, HIV testing, AIDS, and any AIDS-related syndromes. It also includes any information concerning cancer, cancer testing, and cancer results. I agree that a copy of this release or a fax of this release shall be as valid as this original release. Please send copies of all requested information as soon as possible to the address listed below:

Patient's Name _____

Patient's Address _____

Patient's Date of Birth _____

Patient's Social Security Number _____

Please release my medical records from (Name, Address, Phone Number, Fax Number):

_____

_____

_____

Please send my medical records to (Name, Address, Phone Number, Fax Number):

_____

_____

_____

This authorization of release may remain effective from _____ until _____ .

This agreement will become void with my written consent deeming otherwise.

Patient's Signature: _____ Date: _____

Parent/Guardian (If a minor) _____ Date: _____

Witness:_____

1000 S. Durkin Dr. Springfield, IL 62704 P: 217.726.0422 F: 217.726.0424 www.WellnessSpringfield.com