

WHOLE FAMILY WELLNESS CENTER
Authorization for Release of Medical Records

Patient Name _____ Date _____
Address _____
City _____ State _____ Zip Code _____
Phone _____ Email _____

I, _____, authorize the Jill Stevens, L.Ac.,
of the Whole Family Wellness Center to release my medical records to the
following practitioner(s):

_____.

The release of my medical records can include but is not limited to health history, lab
results, progress notes, & treatment plan.

With my signature below I hereby authorize the release of my medical records:

Patient Signature _____ Date _____