WELLNESS WORKS, LLC
AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Name: ____________________________________ Date of Birth: _____/_____/_____

Emergency Contact: ____________________________ Phone #: (____) _____________

I authorize Release of Information including diagnoses, records, and examination rendered at the time of visit to be released to:

Name: _______________________________________ Relationship: _______________

Address: _____________________________________ Phone #: (____) _____________

Name: _______________________________________ Relationship: _______________

Address: _____________________________________ Phone #: (____) _____________

( ) I do not want information released to anyone.

RECEIPT OF NOTICE OF PRIVACY PRACTICES

My signature on this form acknowledges that I have received a copy of Wellness Works, LLC Notice of Privacy Practices. I understand that this document provides an explanation of the ways my information is used or disclosed by Wellness Works, LLC.

____ _________________

Signature Date