6508 Deer Pointe Drive Salisbury, Maryland 21804
Telephone: 410-742-6016

AUTHORIZATION TO RELEASE INFORMATION

Name: ___________________________ Date of Birth:

I hereby authorize The Personal Wellness Center to (check one): __X___ Obtain from the following

__X___ Release to the following

Name:____

Address: ____

Phone: ____________________Fax:_______________________Email:____________________________

The following information pertaining to services received: _______________________________________

____

The records are required for the specific purpose of: ____

____

I understand that my authorization will remain effective one year from the date of my signature, and that the information will be handled confidentially in compliance with all applicable federal laws.

I have read and understand the nature of this release.

____ ____________________

Signature Date

____ ____________________

Parent/Guardian Signature Date

____ ____________________

Witness's Signature Date

Rev. Jan. 2020