Optimized Wellness Center

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

DATE: _____

I HEREBY REQUEST THAT MY MEDICAL RECORDS BE RELEASED TO:

Dr. Tim Heath, DC and/or Dr. Nina Campagna ND
Optimized Wellness Center
info@optimizedwellnesscenter.com

I ASK THAT MY RECORDS BE:

☐ Hand Carried ☐ Mailed ☐ Faxed

TO FURNISH all requested medical information to the person or entity names above.

If I have been tested, treated, or diagnosed in connection with any sexually transmitted disease, drug or alcohol abuse, and/or mental illness, you are specifically authorized to release to the person or entity names above all information or medical records relating to such diagnosis, testing, or treatment unless specifically excluded below.

I understand that the doctor from whom I request records cannot limit or control the subsequent use or dissemination of medical information by the party to whom I request the information be furnished. This request is a free and voluntary act by me. I hereby release the doctor from whom this request is made and his staff from all legal responsibility that may arise from the release of the medical information hereby authorized.

SPECIFICALLY INCLUDE:

MEDICAL RECORDS	(___)
X-RAYS	(___)
LAB RESULTS	(___)
OTHER_____	(___)

PATIENT NAME *(Print Please)* _____

PATIENT NAME *(Signature Please)* _____

DATE OF BIRTH: _____ **SOCIAL SECURITY #:** _____

IF PATIENT IS A MINOR (under 14 years of age), PARENT OR LEGAL GUARDIAN SIGNATURE BELOW:
Print name _____Sign name_____

NAME: _____ **SIGNATURE:** _____