Authorization for Release of Prescription History

Patient Information:

- Full Name: _____
- Date of Birth: _____
- Address: _____
- Phone Number: _____

I, the undersigned, hereby authorize Wheat State Holistic Healthcare, LLC to obtain my prescription history.

Purpose of the Release:
[ ] Personal Records
[x] Continuity of Care
[ ] Other (please specify): _____

Timeframe for Records:
[x] All prescription history
[ ] Specific timeframe: From _____ to _____

I understand that this authorization is voluntary and that I may revoke it at any time by providing written notice to the practice, except to the extent that actions have already been taken based on this authorization.

Signature and Date:

- Signature: _____
- Date: _____

Witness (if required):

- Witness Name: _____
- Witness Signature: _____
- Date: _____

Thank you for your attention to this matter. If you have any questions, please contact us at:
Wheat State Holistic Healthcare, LLC
PH 316-867-6060
FAX 316-252-1247
admin@wheatstatehealth.org