Morgan Webb, MSN, APRN, PMHNP-BC
31 Gooden Ave Dover, DE 19904
Olivebranchintegrative@proton.me
P: 302-242-5463
F: 885-583-3724

Release of Medical Records

I authorize the below named health care provider to release the information or records specified upon request to Olive Branch Integrative Mental Wellness, LLC.

Provider Name:_____ Phone #:_____ Fax #:_____

Please release the information to:
Olive Branch Integrative Mental Wellness, LLC
31 Gooden Ave Dover, DE 19904
(P) 302-242-5462 (F) 855-583-3724

Patient Name:_____ DOB:_____/_____/_____

☐ Entirety of Medical Record during the time I was under the providers care ***OR FROM THE FOLLOWING DATES***
Medical Record from ____/____/_____ to ____/____/_____

Specific Information Authorized to be released:

☐ Entire Medical Record: Including patient histories, office notes, test results, all mental health records including substance abuse notes, referrals, billing records, insurance records, and records received from other healthcare providers.
OR OTHER:_____

This information will be used for the purpose of the following as needed:
- Investigating an allegation of abuse - Legal Representation - Providing advocacy services
- Other activities at the request of the individual - Verifying my eligibility for services offered
*I understand that I am not required to sign this authorization and that my health care or payment for care will not be affected by my refusal
*Federal privacy regulations will no longer apply to the information disclosed and that Olive Branch Integrative Mental Wellness, LLC may redisclose the information.
*I am entitled to receive a copy of this authorization
*A copy of the authorization may be utilized with the same effectiveness as an original

_____ _____
Signature of Patient or Representative Date