

Great Health Holistic

Release Form

Name : _____

Date : _____

I, the undersigned, fully understand that my appointment is with Holistic Practitioner, Peter Morrell. This appointment **does not** include a physical examination and is not intended to replace medical testing and/or diagnosis by a medical physician. I also understand that I am **not to discontinue any prescription medications or treatments** without consulting with the medical physician by whom they were prescribed.

All patient records at Great Health Holistic are confidential and will not be released without my written consent.

Signature: _____ **Date:**

If the patient is a minor (under 18 years) Guardian Name:

Guardian Signature: _____ **Date:**

Relationship _____ **to** _____ **minor:**

If at any time you have questions, concerns or problems relating to your holistic program please call OR have your medical physician call our office at 508-212-3790. In case of an emergency please call your medical physician.

How did you hear about our services?

If you would like to receive information about specials, free lectures or additional services via email, please provide your email address. Please note, Great Health Holistic does not sell or otherwise share any contact information for our patients.

My email address:
