Balanced
Health and Wellness

26400 La Alameda, Suite 208, Mission Viejo, CA 92691

Ph~ 949.606.4698 ~~~ bernadette.balancedhealth@gmail.com

Consent to RELEASE or OBTAIN Medical Records

Patient name	Date of birth		
Patient street address	City	State	Zip
Home phone	Work phone		

I give permission to _____ to RELEASE or OBTAIN the following medical and billing information about me *(check all boxes that apply)*:

- ☐ Scheduling/Appointment information
- ☐ Medical information, including my symptoms, diagnosis, medications and treatment plan
- ☐ Behavioral health information, including my symptoms, diagnosis, medications and treatment plan
- ☐ Chemical dependency information, including my symptoms, diagnosis, medications and treatment plan
- ☐ Lab/test results
- ☐ Billing and payment information
- ☐ Other (describe): _____

_____ has my permission to RELEASE the above information to:

_____ has my permission to OBTAIN the above information from:

_____

_____

_____

I understand that this information shall be in effect until stated otherwise. It may be revokes at any time by giving oral or written notice to the medical office. A photocopy of this authorization shall constitute a valid authorization. I understand once my medical records have been released, the medical office cannot retrieve them and has no control over the already released copies.

I understand that there may be a fee of $20.00 for the transfer of my medical records (except in cases of doctor-to-doctor).

Should my case require review by governing agency or another medical professional actively involved in my care to make a final determination, it is with my consent that a copy of these records will be submitted to the agency or medical professional for this review.

Date _____

Signature of Patient/Authorized Representative **X** _____

If authorized representative, please sign and attach copies of supporting legal documentation.

Reason patient unable to sign _____