



—Medical Release—

Name: _____

DOB: _____

Address: _____

Phone: _____

Email: _____

I hereby authorize Balanced Wellness Integrative Health staff to disclose any pertinent medical information to:

Name/Business: _____

Address: _____

Phone: _____

Email: _____

Please provide any specific requested information you would like shared with this provider: _____

Signature: _____