One Wave Wellness

Date_____:

Authorization for Release of Information

Print Name (First, MI, Last):_____

Date of Birth (mm/dd/yyyy):_____

My Authorization

I, _____, hereby authorize One Wave Wellness and its affiliates to disclose the following health information:

- All my health information
- My health information related to the following treatment or condition:

  _____

- My health information covering the following time frame:_____
- Other:_____

Recipient

The following recipient is authorized to receive the indicated above information:

Name (First, Last or Business Name):_____

Address:_____ City:_____ State:_____ Zip Code:_____

Phone:_____ Email:_____

This Authorization Expires

- Never
- On the following date (mm/dd/yyyy):_____

The purpose of this authorization is for One Wave Wellness to be able to disclose the indicated information to the aforementioned party for the time period indicated. I have given this consent on my own accord and have answered all questions to the best of my knowledge.

Signature:_____