Medical Release

Patient Name: _____
Address: _____
_____

Date of Birth: _____

Beyond Wellness Healthcare LLC, is authorized to furnish to receive from

Recipient/Discloser:

_____

For the purpose of:

_____

I AUTHORIZE RELEASE OF THE FOLLOWING MEDICAL RECORDS:

- **I GIVE PERMISSION TO RELEASE ALL MY MEDICAL RECORDS including information and records or copies of records relating to the history, diagnosis, treatment, or services rendered to me in connection with any condition or disease. This includes permission to release POTENTIALLY SENSITIVE INFORMATION which may include information concerning my treatment of Mental Illness, Human Immunodeficiency Virus, Alcoholism, Drug use/dependency, venereal disease, sexual assaults, abortion, illegitimacy of birth, communications to social workers and or / psychotherapist, psychologist, if any.**

- **I GIVE PERMISSION TO RELEASE ONLY THE RECORDS specifically described below:**

  _____

I release Beyond Wellness Healthcare LLC and the Recipient/Discloser listed above, and any of their providers and staff from all responsibility or liability that may arise from this authorization. I may withdraw this authorization at any time by giving written notification to Beyond Wellness Healthcare LLC provided that I do so in writing and to the extent that you have already disclosed the information on reliance on this authorization.

This authorization expires on __/__/____ (optional) if no expiration date is given, then the authorization shall remain in effect for a period reasonably needed to complete the request.

Signature:

X____

Date: ______________