PURITY
INTEGRATIVE HEALTH & WELLNESS CENTER, PLLC
"WE'RE MORE THAN JUST MEDICINE"

Medical Records Request

I, _____, hereby authorize:

Name of previous clinic: _____

Name of previous physician/practitioner: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

to release the last 2 years of medical records including Labs, and Imaging to:

Purity Integrative Health & Wellness Center, PLLC

Fax to: 888-397-1514

I hereby consent to the release of the specified information relating to diagnosis, testing or treatment to the person or entity named above. I understand that such information cannot be released without my informed consent. I acknowledge I have fully reviewed and understand the contents of this authorization form. My signature below indicates that I hereby agree to and authorize the release of patient health information to the above named person or organization. You have the right to revoke or cancel this authorization, in writing, at any time. I understand that I do not have to sign this authorization in order to get health care benefits (treatment, payment, enrollment, or eligibility for benefits).

Printed Name of patient:_____ DOB:_____

Printed Name of guardian:_____

Signature: _____ Date: _____