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

RECORDS RELEASE

I, _____, hereby authorize:

Name of previous clinic: _____

Name of previous physician/practitioner: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

to release ____ all medical records, ____ labs, _____ physician notes, ____ imaging to:

Purity Integrative Health & Wellness Center, PLLC
165 Commons Loop Suite B, Kalispell, MT 59901
Fax to: 406-890-2067

Please mail to the above address or fax to 406-890-2067 and please include all information from the dates _____ to _____.

I certify that the information is being released by my knowledge and consent to allow me to continue seeking optimal medical care. I agree that this is a one-time request and any further requests will require an additional release form.

Printed Name of patient: _____ DOB: _____

Printed Name of guardian: _____

Signature: _____

Date: _____

Revised 10/10/23