CARY HOLISTIC HEALTH, LLC
222 Ashville Avenue, Suite 10 Cary, NC 27513
919-858-1004 Fax: 919-233-6052

AUTHORIZATION TO RECEIVE MEDICAL INFORMATION

Patient's name: _____ DOB: _____

Street Address: _____ SSN: _____

City, State, Zip code: _____ Phone: _____

At the request of the individual, I _____, do hereby authorize

Name of company/person: _____

Address: _____

Phone: _____ Fax: _____

TO RELEASE THE FOLLOWING:

____ Progress Notes ____ Laboratory Reports

____ Specialist Correspondence ____ Radiology Reports

____ Hospital reports ____ EKG

____ Other _____

____ I do ____ I do NOT authorize release of information related to AIDS or HIV Infection, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.

RELEASE INFORMATION TO:

CARY HOLISTIC HEALTH, LLC
222 Ashville Avenue, Suite 10 Cary, NC 27513
Phone: 919-858-1004 Fax: 919-233-6052

PURPOSE OF DISCLOSURE:
____ Change of Doctor ____ Other: _____

This authorization shall be in effect until _____ at which time this authorization expires.

I understand I may cancel this request with written notification but that it will not affect any information released prior to notification of cancellation.

Signature of individual or guardian: _____ Date: _____