Release of Medical Information
Center for Family Wellness

I authorize the use / disclosure of health information about me as described below.
Patient Name:

Patient Date of Birth:

This information is to be provided by:
Name / Organization:

Fax:

Information to be provided to:
Center for Family Wellness, PA
P. O. Box 24506
Winston-Salem, NC 27144
Office: 336-760-9355
Fax: 866-593-6641

Information Requested:

Progress Notes	Lab Reports	Surgical Notes	Consultations
Hospital Reports	X-Ray / MRI Reports	Other:	

For Dates of Services from to

Purpose of Information Release:

Further treatment	Insurance claims
Workers' Compensation	Legal Request
Other:	

Date: Signature: