

Whole Health Associates
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RECORDS RELEASE AUTHORIZATION

I, _____, hereby request that Whole Health Associates release a report of my laboratory tests, diagnosis, treatment, prognosis and recommendations, as well as other data pertinent to my treatment, from the dates _____ to _____, to the following medical practitioner:

Name:

Mailing address:

PO box or street address

— City State Zipcode

Phone #: _____ Fax #: _____

Patient's signature:

Address: _____

Date of request: _____

Witnessed: _____