360 Wellness Centers AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS TO 360 WELLNESS CENTERS

**Patient Information**

**Patient Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Street Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_\_\_\_**

**Releasing information to: Susanne Landgrebe, ARNP,FNP-C**

**360 Wellness Centers 2675 N Ankeny Blvd, Ste 109 Ankeny, IA 50023**

**Phone: 515-720-4377 Fax: 515-964-7226**

**Purpose of Release**

**\_\_Transfer \_\_Insurance \_\_Referral \_\_Moving \_\_Legal \_\_Per Patient Request \_\_\_Other\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Releasing information from:**

**Clinic/Facility Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_ Zip \_\_\_\_\_\_**

**Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name of Provider/Service Dates**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ / \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ / \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Information to be Released (Check all that apply)**

\_\_\_ Complete Medical Records \_\_\_ Radiology Reports/Images \_\_\_Labs \_\_\_Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that information to be released may include material that is protected by Federal and/or State law

concerning mental health, substance abuse treatment, AIDS related information and genetics unless I specifically

deny the release by initialing the category below:

Please initial by any category you **DO NOT** want to be released

\_\_\_\_Substance Abuse (Drug or Alcohol) \_\_\_\_Mental Health \_\_\_\_AIDS Related (Diagnosis & Test Results)

How would you like to receive the records: \_\_\_Mail \_\_\_\_Email \_\_\_\_\_\_Fax

I **SPECIFICALLY AUTHORIZE** disclosure and redisclosure of this confidential information to the person or entity listed above. In

Order for the records to be released, you must sign below. If mental health information is being disclosed, I acknowledge receipt

of a copy of this authorization.

Signature of Patient or Patient’s Legal Representative\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name and Relationship of Patient’s Legal Representative\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please fax to 515.964.7226 or mail to 360 Wellness Centers, 2675 N Ankeny Blvd, Ste 109. Ankeny, IA 50023**