WILLIAMSTON WELLNESS, PLLC

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Today's Date: _____

Patient Name: _____ **Date of Birth:** _____

The above named person must indicate when this authorization is to expire _____

The above named person is or has been a patient of:

Name of Person, Provider or Facility: _____

Address: _____

Phone: _____ Fax: _____

Email: _____

The person named above authorizes information to be requested by or released to representatives of:

WILLIAMSTON WELLNESS, PLLC.
1235 E. GRAND RIVER RD STE 1-A
WILLIAMSTON, MI 48895
PHONE: 517-655-4234 FAX: 517-798-5676
EMAIL: williamstonwellness@gmail.com

The above named person authorizes the release of the following information:

☐ All information regarding assessment, diagnosis and treatment of patients condition, concern or disease: _____

_____

☐ All information regarding care received by patient between the following dates: _____ to _____

☐ Other Information (specify): _____

Signature of Patient (or authorized representative):

Signature: _____ Date: _____

Printed Name of Patient (or authorized representative): _____

If not signed by patient, indicate relationship of authorizing representative: _____

Signature: _____ **Date:** _____