VITALITY HEALTH

9240 Bonita Beach Rd
Suite 1114
Bonita Springs, FL 34135

MEDICAL RECORDS RELEASE FORM

To request the release of medical information, please complete and sign this form and email it to kurt@vitalityhealthsfl.com

☐ Release my protected health information to me.

Or

☐ Release my protected health information to,

Name: _____

Fax: _____ Phone: _____

Email: _____

If you would like the records mailed, provide the address below.

Address: _____
Street City State Zip

Reason for release: _____

Restrictions (if any): _____

_____

I hereby authorize Vitality Health to release my medical information as requested above. this authorization will remain active for one year to date of signature, unless revoked in writing. I am aware that Vitality Health cannot control how the recipient uses the information, and that laws protecting its confidentiality at Vitality Health may not protect this information once it has been disclosed to the recipient. Information will not be released without a valid signature.

_____
Print Your Name

_____ _____
Your Signature Date