



Medical Records Release Form

By signing this form, I authorize Reis Wellness to **RELEASE** confidential health information about me, by sending a copy of my medical records, or a summary or narrative of my protected health information to the physician/person/facility/entity listed below.

Patient name: _____ Date of Birth: _____

The information to be released is as follows:

Initial next to each selection to also include:

- _____ Mental Health Information
- _____ Genetic Testing Information
- _____ HIV/AIDS Information
- _____ Substance Abuse
Diagnosis/Treatment

Send my protected health information **TO** the following physician/person/facility/entity:

Name: _____

Address: _____

City/State/Zip: _____

Phone: _____ Fax: _____

Signature of Patient or Personal Representative

Date

Printed name

Description of Personal Representative

Reis Wellness

Address: 839 E. Winding Creek Dr, Suite 102, Eagle, ID 83616

Fax: 208-213-2778

Phone: 208-537-2798

Email: info@reiswellness.com