Moorestown
INTEGRATIVE WELLNESS

Release of Private Health Information Form

Patient Name_____ Date of Birth_____

I give permission for Moorestown Integrative Wellness to release/ receive Information from

Person or Agency:_____

Adress:_____

Phone Number:_____email:_____

The following information about the patient: (please check all that apply)

	Diagnostic Assessment
	Dates of Treatment
	Treatment Summary
	Medical Information
	Other:

For the purpose of: (please check all that apply)

	Coordination of Care
	Continuity of Treatment
	Medical Information
	Other:

I understand that I can revoke this authorization at any time, except to the extent that action has already taken place. If not revoked at an earlier date, this authorization will expire one year from the date signed.

Patient Signature Date