Nelson Wellness Center

1543 Beech Grove Road, Roseland, VA 22967 (P) 434. 361. 2650 (F) 434. 361. 2511 www.nelsonwellnesscenter.com

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Client name: _____ DOB: _____

Social Security: _____ Phone number: _____

Client Street address: _____ City: _____ State: VA zip code: _____

I request and authorize Nelson Wellness Center to release healthcare information of client named above to:

Facility name: _____

Facility address: _____

City: _____ State: _____ Zip code: _____

This request and authorization applies to: (please check appropriate selection)

- ○ All healthcare information
- ○ Healthcare information relating to following condition, dates or treatment: _____ _____
- ○ Other: _____

I, _____, understand that I am giving my permission to the above named provider for the disclosure of confidential health care records. A copy of this consent form shall be included with my original records.

Signature of client or legal representative: _____ date: _____

Printed name of client or legal representative: _____