AUTHORIZATION TO RELEASE MEDICAL INFORMATION

TO: ____

____

____

You are authorized to release any and all medical records related to my medical condition and treatment that I may have had during the following time period listed immediately below:

From___________________ to ___________________

To the following person(s), company, or government institution:

ROGUE FUNCTIONAL WELLNESS LLC
761 GOLF VIEW DRIVE STE C
MEDFORD, OREGON 97504
Ph. 541.326.4294
Fax. 541.359.4018

______ My initials here indicate authorization to release all medical records requested.

A photocopy of this authorization shall have the same force and effect as an original.

All prior authorizations are canceled.

I have executed this document on the _____ day of________________ 20___

This Authorization Is Valid For 180 Days From The Date Of Execution.

Name of Patient: ____

Signature of Patient: ____

Address of Patient: ____

City, State, & Zip Code: ____

Phone Number: ________________________________

Date of birth: ___________________ Social Security Number: ____________________