whole child wellness
holistic pediatrics for your child's body, mind, & spirit

Authorization to Release Medical Information From Whole Child Wellness

Attention: Whole Child Wellness, Inc.
1601 El Camino Real, Suite 101
Belmont, CA 94002
Tel: 650-595-KIDS (5437)
Fax: 650-595-5438
E-mail: info@wholechildwellness.com

Re: Patient Name: _____ DOB: _____
Address: _____ City: _____ State: _____ Zip: _____
Tel #: _____ Fax #: _____

I hereby authorize and request Whole Child Wellness to release the following health care information of the patient named above:

This information is to be released to:

Doctor / Hospital / Individual: _____
Address: _____ City: _____ State: _____ Zip: _____
Tel #: _____ Fax #: _____
E-Mail: _____
Delivery Method: ◯ Mail ◯ E-mail ◯ Fax ◯ Other: _____

I understand that I have a right to receive a copy of this authorization upon request. I also understand that this authorization may be modified or rescinded but that such rescission or modification will only be effective when delivered in writing to Whole Child Wellness.
I understand that a record copying fee may apply.

Signature: _____ Date: _____
Printed name of legally authorized individual: _____
Relation to patient: _____