Request for medical records

To be sent to Balanced Body Wellness Centre, LLC

Patient Authorization for Use and Disclosure of Protected Health Information

By signing this I, _____ (patient name), authorize _____ (facility with records), to release health information to Balanced Body Wellness Centre.

Patient Date of Birth: _____ Patient Last 4 Digits of SSN#:_____

_____
Dr. Name/Facility

_____
Address

_____

_____
Phone Number

_____
Fax Number

Balanced Body Wellness Centre
5150 Stilesboro Rd Ste 400
Kennesaw, GA 30152
770-425-6068 ph
770-545-6330 fax

The purpose of this letter is to request copies of my medical records as allowed by the Health Insurance Portability and Accountability Act (HIPAA) and Department of Health and Human Services regulations be released and sent to the above named facility.

I was treated in your office between dates:_____. I request copies of all health records related to my treatment. Please include all blood tests, physician notes, medical history form, any referrals and consultations.

Please fax or mail the requested records to me at the above address.

Thank you,

_____ _____

Signature Date Printed name