CITY OF OAKS WELLNESS

1004 Dresser Ct, Ste 102
Raleigh, NC 27609
ph: 919-266-0175
fax: 833-450-4826

MEDICAL RECORDS RELEASE FORM
TO: City of Oaks Wellness

PATIENT INFORMATION:	Name:	
	Address:	
	Phone:	Date of Birth:

RECORDS REQUESTED FROM:	**Provider / Facility Name:**	
	Address:	
	Phone:	**Fax:**

I consent and authorize the above named Provider / Facility to release copies of my medical records as follows:

- ☐ ALL of my medical records
- ☐ ONLY send records from (Date) _____/_____/_____ to (Date) _____/_____/_____
- ☐ Only send specified records as follows:

_____

_____

PURPOSE:	The purpose of releasing this data shall be for: ☐ Continued Patient Care ☐ Attorney / Legal ☐ Disability / Workers Comp ☐ Personal ☐ Other _____

SEND RECORDS TO:	**CITY OF OAKS WELLNESS** **1004 Dresser Ct, Ste 102, Raleigh, NC 27609** **ph#: 919-266-0175 / fax#: 833-450-4826**

SIGNATURE:		
	(Signature of Patient, Parent, Legal Guardian)	*(Date)*