CITY OF OAKS WELLNESS

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

RELEASE OF INFORMATION - REQUEST TO SEND RECORDS
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:

Why am I requesting my records?

- ☐ Continued Patient Care/Patient Treatment
- ☐ Attorney / Legal
- ☐ Disability / Workers Comp
- ☐ Other_____
- ☐ Transfer of Care
- ☐ Change of Insurance
- ☐ Personal

SEND RECORDS TO:

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I understand that I may revoke this consent at any time except to the extent that action based on this consent has already been taken. This consent will automatically expire after 90 days from the date on which it is signed.

SIGNATURE: *(Signature of Patient, Parent, Legal Guardian)*	***PRINT NAME:***	***DATE:***
	Signature:	