HELIOS
INTEGRATED MEDICINE
Health Illuminated

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS/INFORMATION

I, _____, date of birth, _____, hereby authorize to release and/or exchange information including my medical records

(From:)_____
_____
_____
Individual, Physician or Facility (Name & Address)

Fax: _____

(To:) _____
_____
_____
Individual, Physician or Facility (Name & Address)

Fax:_____

Information to be released:

_____ All medical records at this facility.

_____Only some portion of records maintained at this facility, specified below.

_____

May the designated information be discussed by telephone? _____ Yes _____No

This consent is in effect until _____ (form will expire after one year). I understand that I may revoke this authorization, in writing, at any time unless/until the records release has already taken place. A copy of this authorization may be utilized with the same effectiveness as an original.

_____ _____
Patient Name (Print) Guardian Name (if patient is a minor) (Print)

_____ _____ _____ _____
Patient Signature Date Guardian Signature Date

_____
Relationship to patient

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