Name: _____ DOB: _____

RELEASE OF MEDICAL INFORMATION

For any / all signed releases on this document, I fully understand that each releases of information must be terminated in writing. _____ initial

Primary Physician: _____
Practice: _____
Address: _____
Phone: _____ Fax: _____
I authorize the release of verbal and/or written information between Advantage Nutrition & Wellness, LLC and the above named physician/medical group: _____ Date: _____
Signature

Secondary Physician / Specialist: _____
Practice: _____
Address: _____
Phone: _____ Fax: _____
I authorize the release of verbal and/or written information between Advantage Nutrition & Wellness, LLC and the above named physician/medical group: _____ Date: _____
Signature

Secondary Physician / Specialist: _____
Practice: _____
Address: _____
Phone: _____ Fax: _____
I authorize the release of verbal and/or written information between Advantage Nutrition & Wellness, LLC and the above named physician/medical group: _____ Date: _____
Signature

Therapist / Specialist or Other: _____
Practice: _____
Address: _____
Phone: _____ Fax: _____
I authorize the release of verbal and/or written information between Advantage Nutrition & Wellness, LLC and the above named physician/medical group: _____ Date: _____
Signature

Therapist / Specialist or Other: _____
Practice: _____
Address: _____
Phone: _____ Fax: _____
I authorize the release of verbal and/or written information between Advantage Nutrition & Wellness, LLC and the above named physician/medical group: _____ Date: _____
Signature