RevitaLife Phone # (314) 475-3126 Fax # (314) 475-3127

I, _____ (DOB: _____), hereby authorize and request:

RevitaLife Wellness Center

777 S. New Ballas Road, Suite 100E

Saint Louis MO 63141

To provide records to the office personnel of:

Healthcare Provider: _____

Address: _____

Phone # : _____ Fax # : _____

- o The entire medical record, excluding mental health treatment, alcoholism treatment, drug abuse treatment, and HIV/acquired immune deficiency syndrome (AIDS) records.

To be disclosed, the following items must be checked:

- o Mental Health Treatment Records
- o Alcoholism Treatment Records
- o Drug Abuse Treatment Records
- o HIV/AIDS Records
- o X-ray/Imaging Reports
- o Operative Notes
- o Other _____

I authorize you to release all of the information requested, which may include information relating to psychiatric treatment/testing, or treatment relating to drug or alcohol abuse, or information concerning AIDS antibody testing, if any, including the test results thereof, without limitations placed on dates, history of illness, and/or diagnostic testing.

Reason for release: _____

The information to be released is confidential. Further disclosure by the receiving party is strictly prohibited except as specifically authorized.

I understand that I may revoke this consent at any time, except if action has already been taken in regards to this request. This consent automatically expires upon compliance of this request and will not serve for any future request.

Signature: _____ **Date:** _____

Legal guardian if under 18 or if POA is assigned: _____