RevitaLife
MEDICAL & SPA

Christina Robins, MD | Carey Weltz, FNP | Karen Delia, FNP | Andrea Martin, PA-C

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

Healthcare Provider/Office: _____

Address: _____

Phone #: _____ Fax #: _____

To provide records to the office personnel of: Revitalife Wellness Center

13354 Manchester Road, Suite 100

Des Peres, MO 63131

PHONE: 314-475-3126 FAX: 314-475-3127

__ 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:

__ Mental Health Treatment Records

__ Alcoholism Treatment Records

__ Drug Abuse Treatment Records

__ HIV/AIDS Records

__ X-ray/Imaging Reports

__ Operative Reports

__ 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 test results thereof, without limitations placed on date, 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 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: _____