



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

I, \_\_\_\_\_ (DOB): \_\_\_\_\_, hereby authorize and request:

Revitalife Wellness Center 13354 Manchester Road, Suite 100 Des Peres, MO 63131

To provide records to the office personnel of:

Healthcare Provider/Office: \_\_\_\_\_

Address: \_\_\_\_\_

Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

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: \_\_\_\_\_