AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

Patient's Name:________________________________ Date of Birth:_______________________

Previous Name:________________________________ Social Security #:__________________

I, the above named person, request:

Name: ____

Address: ____

City: ______________________________ State:_________ Zip Code:____________

To fax my health care information to:

Name: **DeWayde C. Perry, M.D.**

Center for Integrative Health and Performance

Fax: **888-864-3381**

This request and authorization applies to:

☐ Health care information relating to the following treatment, condition and/or dates:

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☐ All health care information

☐ Other:____

This release expires 60 days after date signed

Patient Signature:____________________________________Date Signed:_____________________