Health Done Wright, Inc

Release of Medical Information Authorization Form

(Print Name) _____ (Date of Birth) _____

Consent to the release of my medical records to

Health Done Wright, Inc. office of Dr. Angela Overstreet Wright
2607 Commons Blvd, Augusta GA 30909
Office Phone [706]-750-8601 Records can be mailed to the address above or Fax to [866]-610-4814.

I understand the information may include reference to psychiatric/psychological care, drug and alcohol abuse information, and/or result of test for all infectious diseases including HIV/AIDS. I understand that I have a right to revoke this authorization at any time. I understand that if I wish to revoke this authorization I must do so in writing and present my written cancellation/revocation to Dr. Angela Overstreet Wright or the office manager. I understand the cancellation/revocation is only applicable for the date submitted and does not apply to information that has already been released in response to this authorization.

_____ _____

Signature Date

This section to be completed by the office staff

The patient above has consent for our office to retrieve a copy of their medical records from your office.

Name of healthcare provider or facility _____

Phone _____ Fax _____

Please share the following information:

_____

____Office notes including H&P _____

____Lab Results for _____

____X-Ray images of _____

____Procedure Report for _____

____Hospital Notes from _____

____Emergency Notes from _____

____Immunization Records _____

____Medication List _____

____Psychotherapy Notes _____

____ Other _____