Health Done Wright, Inc

Release of Medical Information Authorization Form

I, _____ _____/ _____/ _____
(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 address above or
Faxed to [762]-994-1086 or [866]-493-3966

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. Unless otherwise cancelled or revoked, this authorization will expire one year from the date of signature below

_____ _____
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:

Address _____
____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 _____