REVOLUTION
HEALTH & WELLNESS

2865 E. Skelly Dr.
Tulsa, Ok 74105
Phone: 918-935-3636
Fax: 918-935-3635

CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

Patient Name: _____ DOB: _____

Address: _____ Phone: _____

I hereby authorize REVOLUTION HEALTH AND WELLNESS to disclose the following medical information to (choose and fill out one):

Attention / Provider Name: _____Phone_____

- O At Fax Number: _____
- O Or Email: _____
- O Or Mailing Address: _____

Information to be disclosed:

_____ Discharge Summary
_____ Physiological Evaluation
_____ Consultation Reports
_____ Progress Notes
_____Education Information
_____Lab Work
_____All Information
_____Other_____
_____

I, the undersigned, understand that I may revoke this consent at any time except to the extent that action has been taken reliance on it.

TO THE PARTY RECEIVING THIS INFORMATION: This information has been disclosed to you from records whose; confidentiality may be protected by federal law. If so, federal regulations prohibit you from making any further disclosure of it without specific written consent of the person to whom it pertains, or as other wise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.

DATE:_____ _____
Patient's Signature

WITNESS: _____ _____
Signature of Parent, Guardian, or
Authorized Representative