

Body Renew, LLC

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MEDICAL RECORDS REQUEST AUTHORIZATION

Patient's Legal Name (please print)

Date of Birth

Address

Phone Number

City

State

Zip Code

I hereby authorize _____

Doctor's Name or Clinic (the clinic who has the records you want)

Their Clinic Address

City

State

Zip Code

Clinic Phone Number

Clinic Fax Number

to disclose protected health information of the person listed above to **Body Renew, LLC.**

Reason to release protected health information (optional): _____

Type of records requested:

Laboratory reports (for previous 2 years)

Other _____

I acknowledge and hereby consent to such that the released information may contain alcohol, drug abuse, psychiatric, or HIV results. I understand that this authorization may be revoked by me at any time except to the extent that action has been taken in reliance upon it. I understand that there may be a fee involved with the fulfillment of this request. I understand that the term, "entire record", means that only records generated by the named facility will be released.

I have read the above and authorize the disclosure of the protected health information.

Signature of Patient or Legal Guardian

Date

Patient's Printed Name