AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____

Date of Birth: _____ Social Security #: _____

I request and authorize _____ to release healthcare information of the patient named above to:

Turning Point Wellness, Inc.
841 Blossom Hill Rd, Suite 108
San Jose, CA 95123
Phone: 408-475-8876
Email: Info@TurningPointMT.com

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: _____

_____

☐ All healthcare information

☐ Other: _____

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to Turning Point Wellness.

☐ Yes ☐ No I hereby authorize Turning Point Wellness to release any and all physical health information to process my insurance claim, discuss my health condition(s) with my doctor and other health providers, and/or to my attorney.

☐ If checked, this authorization expires on: _____, otherwise it does not expire.

Patient Signature: _____ Date Signed: _____