Physician Assisted Wellness, PLLC
Jonathan L. Sheline, MD, MS
112 Swift Ave.
Durham, NC 27715

Authorization for Release of Medical Information

Please mail records. DO NOT FAX!!

Please send this form *directly* to the provider you wish us to receive information from; you will need more copies of this form if you need records from multiple providers. Thank you!

Your Name:_____ Birth Date:_____
Address:_____
Social Security Number (this is helpful, but optional): _____

I, the undersigned, do authorize and request that the following provider send my medical records to: *Physician Assisted Wellness, PLLC*; 112 Swift Ave, Durham, NC 27715

Provider name: _____

Provider address: _____

Please send records for care and treatment that I received from: _____ to _____ (give dates).

Please include: ( ) All records from these dates
( ) Only these: _____

Purpose of record transfer:_____.

This authorization will be valid for a one year period of time. I may revoke this authorization at any time by doing so in writing.

I acknowledge that information to be released may include material that is protected by state and/or federal law applicable to mental health, alcohol/drug abuse, HIV/AIDS or all of these. My signature authorizes release of all such information as specified above.

_____ _____
Signature of Patient or Patient's Authorized Representative Date

_____ _____
[Relationship of Authorized Representative] Witness Signature/ Date