Physician Assisted Wellness, PLLC
Jonathan L. Sheline, MD, MS
180 Providence Rd., Suite 5
Chapel Hill, NC 27514-2206

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*; 180 Providence Rd, Suite 5, Chapel Hill, NC 27514-2206

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