Solstice Medicine and Wellness, LLC
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Authorization to Release Medical Records

Patient Name: ______________________________________ Date: ______________

Patient DOB: ____________________

- Release from ______________________________________
- Release to ____
- Complete Medical Records
- Labs and Radiology
- Pathology
- All Chart notes between _____________________________
- Other ____

Restrictions: Only medical records originated through this healthcare facility will be copied unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified.

I understand that I may revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the staff member of Solstice Medicine and Wellness. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides the insurer with the right to contest a claim under my policy.

_______________________________ ______________

Patient Signature Date