ADVANCED HEALTH SERVICES, LLC
Email: advancedhealth14@gmail.com
Website: www.OurAdvancedHealthServices.com
Phone: 561-596-7581 FAX: 561-355-5155

HEALTH CONDITION AND HISTORY RELEASE FORM TO FAMILY MEMBER / SPOUSE / FRIEND:

Please release my / my child's medical information to:
____

Relationship to the Pt/Client:
____

Address:
____

____

Telephone: ______________________________Fax: ____________________________________

Email Address: ____

Please accept this release as authorization to discuss my medical case / health history or condition with this named individual and to offer them my medical / wellness files as needed.

Patient/Client name: ____

Patient/Client Date of Birth: ____

Patient/Client Social Security #: ____

Patient/Client Signature: _______________________________________ Date: ____/____/____

Legal Guardian Signature: _____________________________________ Date: ____/____/____