WholeLife
Authentic Care

Release of Medical Records to WholeLife Authentic Care

Patient Name:___________________________Other Names:_____________________________

Address:________________________________Date of Birth: ____________________________

City: ____________________________State:_______________________Zip: ______________

Phone:_________________________________SSN: (optional)____________________________

I hereby authorize (Name of person/agency
from whom information is requested): ____

Please include address:____

To release information to: WholeLife Authentic Care
1000 Bonnie Brae Ave,
Fort Worth, Texas 76111
FAX: 855-552-6041

Medical Information to be released to include:

Complete Medical Record _________Progress notes dated ________________________

Labs dated __________________________Other ______

SPECIFIC AUTHORIZATION FOR RELEASE
OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW.

I specifically authorize the release of data and information related to:

Substance abuse (alcohol/drug abuse) Yes No Not Applicable

Mental Health Yes No Not Applicable

HIV-Related Information (AIDS related testing) Yes No Not Applicable

Patient or Legal Guardian:____Date:____________

This authorization for release of information shall remain in effect no longer than ninety (90) days.

Revised August 2020