AUTHORIZATION TO RELEASE MEDICAL RECORDS

I hereby authorize _____, to release medical records on the following patient:

Name_____

Date of Birth_____

Address_____

Telephone_____

Records are to be transferred to:

Vitality Medical and Wellness Consulting
3009 N Ballas Rd., Bldg B, Ste 215
Saint Louis, MO 63131
Fax: 314-272-3938

Records will be Transferred Electronically

_____

Patient Signature Date