NEW BEGINNINGS
Mental Health and Wellness

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

If you have any doctors that you would like us to request medical records from, please fill in the line below with their name. Request additional forms if needed.

_____
(Previous Doctor's Name/Clinic Name)

I hereby authorize the release of my medical records to New Beginnings Mental Health and Wellness. Please include all medical treatment within the past year, including laboratory test results for continuity of care.

_____ _____
Printed Patient Name Date of Birth

_____ _____
Signature of Patient Date

New Beginnings Mental Health and Wellness
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