



Body Anew

Traditional Chinese Medicine for Health

Medical Record Release Form

Last Name	First Name	Middle Name
Address		Apartment
City	State	Zip Code
Date of Birth	Telephone	Alternate Telephone
<p>I hereby grant the following entity/doctor's office permission to release information contained in the medical record of the above named patient (please print the name of the doctors/specialists who currently possess your medical information).</p>		
Information Requested (please be specific)		
Restrictions and/or Exclusions (if any)		
Purpose of Release		
<p>The purpose of this release is to provide my complimentary/alternative medicine (CAM) provider with details surrounding the condition(s) that he is treating.</p>		
<p>The information described above is to be released directly to my CAM provider at</p> <p>Body Anew Acupuncture T. Justin Landers, L.Ac. 319 Fulford Ave. Bel Air, MD 21014</p>		
<p>I hereby authorize my doctor/specialist named above to release any medical information as requested above. This may include information about drug or alcohol abuse, psychiatric, social work, or other protected information unless otherwise excluded. I am aware that my doctor/specialist cannot control how the recipient uses or shares the information but that the laws protecting its confidentiality are binding to both my doctor/specialist and to Body Anew Acupuncture. I am further aware that my medical information will not be released without a valid signature below.</p>		
Signature of Patient		Date
Signature of Parent or Guardian		Date