I HEREBY REQUEST AND AUTHORIZE:

- □ Asana Wellness Center
- □ Florida Wellness and Rehabilitation Center of Homestead
- □ Florida Wellness Center of Tallahassee
- □ Jacksonville Injury & Rehab

TO RELEASE THE HEALTH RECORDS SPECIFIED BELOW:

______________________________	____________	______________
patient name	date of birth	date(s) of service
		□ All Dates

- □ All General Medical Records - or -
- □ Limited Records (Specify): ______________________________

THESE RECORDS ARE TO BE PROVIDED TO:

____

name of person or institution information is being disclosed to

RELEASE VIA (provide delivery information for option chosen):

- □ Fax ______________________________
- □ Email ______________________________
- □ Regular Mail ______________________________

____

____

AUTHORIZED BY:

______________________________	____________
Signature of patient or Authorized representative	date

Authorized representative Printed Name: ______________________________

- □ Parent
- □ Legal Guardian
- □ Legal Representative
- □ Other (specify) ______________________________

*if legal guardian or representative, proof of status must accompany this form

Patient Records Department
207 N. Krome Avenue, Ste 210
Homestead, FL 33030
Fax: 305-246-0059

Authorization for Release of
Patient Medical Information