

**Vitality Health & Wellness, LLC**  
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**Medical Records Release**

Date: \_\_\_\_\_  
From : \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I hereby authorize you to release the complete medical records in your possession concerning any medical health/treatment during the period from \_\_\_\_\_ to \_\_\_\_\_

To: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Patient Name: \_\_\_\_\_  
Signature: \_\_\_\_\_  
Social Security Number: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_  
Witness: \_\_\_\_\_