Vital Well-Being Center, Inc.

210 S. Pinellas Ave., Suite 106
Tarpon Springs, FL 34689

Medical Records Release

727-786-1661 Office
727-785-3783 Fax

I hereby authorize ____

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To release or disclose to:

Vital Well-Being Center, Inc.
210 South Pinellas Ave.
Tarpon Springs, Florida 34689

The following information:

All medical records or other information regarding my treatment including psychological or psychiatric impairments, drug abuse, alcoholism, human immunodeficiency virus (HIV) infection (including acquired immunodeficiency syndrome (AIDS) or tests for (HIV) or sexually transmitted diseases).

I authorize the use of a telefax or photocopy of this form for the release or disclosure of the information described above.

______________________________ ______________________
Patient Name (print) Patient DOB

______________________________ ______________________
Patient Signature Date

Thank you for allowing us to participate in the care of your patient.