AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: ____

Date of Birth: ____________________ Social Security #: ____________________

I request and authorize ____ to release healthcare information of the patient named above to:

Stresstoration LLC
5613 White Willow Dr
Fort Collins, CO 80528
Phone: 970-658-9891
Email: info@mydiyhealth.com

This request and authorization applies to:

□ Healthcare information relating to the following treatment, condition, or dates: ____________________

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□ All healthcare information

□ Other: ____

□ Yes □ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to Stresstoration LLC.

□ Yes □ No I hereby authorize Stresstoration LLC to release any and all physical health information to process my insurance claim, discuss my health condition(s) with my doctor and other health providers, and/or to my attorney.

□ If checked, this authorization expires on: ______________________, otherwise it does not expire.

Patient Signature: ______________________________ Date Signed: ____________________