Healing Path
Integrative Medicine, PLLC
Anne Walch, MHS, PA-C

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Medical Records Release Consent

To:_____

Address:_____

_____

Fax:_____ Phone:_____

Patient name:_____

DOB:_____ S.S.#:_____

I, _____, authorize the release of my medical records to Anne Walch, MHS, PA-C of Healing Path Integrative Medicine.

Please include copies of (circle) :

Office notes | Lab reports | Radiology reports | Surgical reports | Medications | Problem list | Everything

For dates: _____to current date.

Signature: _____ Date: _____

Relationship: ___ self ___ parent ___ power of attorney ___ guardian