ADVANCED WELLNESS CENTER OF PA
Alternative Solutions to Chronic Health Problems

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HEALTH AND MEDICAL INFORMATION RELEASE FORM

ADVANCED WELLNESS CENTER OF PA RELEASE 1

I, _____, give permission to Dr. Christopher Walcott and staff at Advanced Wellness Center of PA to share medical information with my medical doctor, _____, as well as his staff. Also, my medical doctor and staff have permission to share medical information with Dr. Christopher Walcott and his staff.

_____

Patient (Signature) Date

PATIENT INFORMATION 2

Patient Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone #: Home: _____ Cell: _____

MEDICAL DOCTOR INFORMATION 3

Name of Doctor: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone #: Home: _____

COMMENTS 4

Comments: _____