FAX: 617-419-1051 EMAIL: office@THCevaluation.com

PATIENT RELEASE FORM

PATIENT NAME: _____ DOB:_____

I HEREBY AUTHORIZE _____
(Name of Your Medical Provider)

TO RELEASE MY MEDICAL INFORMATION TO THE HOLISTIC CENTER, DR. THOMAS WONG, FOR EVALUATION AND ASSESSMENT OF ALTERNATIVE MEDICAL CARE. THE PATIENT WILL CONTINUE TO BE UNDER YOUR CARE AS PRIMAMRY PROVIDER.

This permission to release medical information is valid for **six (6) months** from date of signature.

SIGNATURE OF PATIENT: _____ DATE: _____

PRINT NAME: _____

MEDICAL PROVIDER FILLS OUT THE FOLLOWING:

1. PRIMARY CONDITION/DIAGNOSIS: _____
_____
2. TREATMENT(S): _____
3. COMPLICATIONS/ALLERGIES: _____

Medical Provider's Signature: _____ Date: _____

Medical Provider's Address: _____

PLEASE FORWARD SIGNED COPY TO THE HOLISTIC CENTER, DR. THOMAS WONG: