Authorization to Release Medical Information
From Vibrant Life Medicine

Attention: Vibrant Life Medicine
286 Engle Street
Englewood, NJ 07631
T: 201-569-6190
F: 201-569-6940
E-mail: hello@vibrantlifemedicine.com

Re: Patient Name: ____________________ DOB: ____________
Address: ____________________ City: ____________ State: _____ Zip: ________
Tel #: ____________________ Fax #: ____________________

I hereby authorize and request Vibrant Life Medicine to release the following health care information of the patient named above:

____

This information is to be released to:

Doctor / Hospital / Individual: ____________________
Address: ____________________ City: ____________ State: _____ Zip: ________
Tel #: ____________________ Fax #: ____________________
E-Mail: ____________________
Delivery Method: Mail E-mail Fax Other: ____________________

I understand that I have a right to receive a copy of this authorization upon request. I also understand that this authorization may be modified or rescinded but that such rescission or modification will only be effective when delivered in writing to Vibrant Life Medicine. I understand that a record copying fee may apply.

Signature: ____________________ Date: ____________
Printed name of legally authorized individual: ____________________
Relation to patient: ____________________