New Beginnings Wellness Center & Spa
927 N. Trenton Street
Ruston, LA 71270
318.255.1155 PH
318.255.3181 FAX

Release of Records

Patient Name: ____ Date of Birth: __________________

Social Security Number: ____________________________

I hereby authorize the release of:

☐X-rays and X-ray Reports	☐Discharge Summaries
☐Progress Notes	☐Pathology Reports
☐Operative Reports	☐Correspondence from other Physicians
☐Lab Reports	Other___________________________

From (Provider Name): ____

Address: ____

To: New Beginnings Wellness Center & Spa
927 N. Trenton Street
Ruston, LA 71270

1. I understand that the purpose for this release is for the continuity of my care.
2. I shall regard a photocopy of this document as valid as the original.
3. I under that these documents shall be mailed, faxed, hand delivered or reported over the phone.
4. I understand that my medical records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law.
5. This document shall be valid for 1 year from the date of signature.

____ ____________________
Signature of Patient or Legal Representative Date

____
Relationship to patient

Any re-disclosure of the following material without the written permission of the person to whom it pertains is strictly prohibited by federal law.