



FRESH MEDICAL FAMILY CLINIC

Let Our Family Care For Yours

PATIENT RECORD RELEASE AUTHORIZATION

I, _____, birth date _____ hereby authorize the release of my medical information and records to OKLAHOMA HEALTH AND WELLNESS CENTER.

Patient Signature

Date

Parent or Legal Representative Signature (relation)

Date

Release FROM:

Release Records TO:

Oklahoma Health & Wellness Center
Fresh Medical
4200 Carriage Way
Weatherford, OK 73096
Office: (580) 774-2214
FAX: (580) 774-5301