MADISON ACUPUNCTURE & COMPLEMENTARY MEDICINE
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6402 Odana Rd, Madison WI, 53719 608-467-9711
www.MadisonAcupunctureMedicine.com

Patient Information Release Request Form

I, _____ (please print name) give full consent so that Madison Acupuncture & Complementary Medicine may consult freely with other physicians and healthcare professionals (whose care I am under) regarding any of my medical treatments or relevant information. This could include the exchange of both verbal and written communications (including lab work).

(*to be filled out by your practitioner*) The following is an authorization to provide Madison Acupuncture &

Complementary Medicine with the following information:

- ○ All recent lab work results
- ○ All medical records
- ○ Other: _____

I am eighteen years of age or older:

- ○ Yes
- ○ No

Client/Patient Signature: _____ Date: _____

Signature of parent or guardian (if applicable): _____

Thank-you for your prompt attention to this request. Please bring or email information to Amy@MadisonAcupunctureMedicine. If you have any questions, please feel free to contact us.

Madison Acupuncture & Complementary Medicine, LLC

Please print, complete and bring forms to your initial appointment. Thank you.