PREMIER WELLNESS INTERNAL MEDICINE, LLC

Michelle Sun, M.D., P.A.
Catheryne Zavodny, M.D., P.A.

Release of Medical Information Designation Form

I hereby authorize one or all of the designated parties listed below to request and receive any protected health information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of designated parties must be verified before the release of any information.

NAME RELATIONSHIP PHONE NO

_____

_____

_____

In the event of an accident or illness that makes me unable to make medical decisions or in the event of my death, I wish to make my medical records available to:

_____

_____

_____

Patient Printed Name _____

Address, City, State, Zip _____

_____

Date of Birth _____

Today's Date _____

Signature _____