

## ASCEND POLYWELLNESS CENTER, LLC AUTHORIZATION TO RELEASE MEDICAL INFORMATION PLEASE READ FORM CAREFULLY AND FILL OUT COMPLETELY

Clients Name:		DOB:
1.	I authorize	2. To Release To:
		Ascend Polywellness Center, LLC
	Name of Sending Person/Organization	Name of Receiving Person/Organization
		7630 Little River Turnpike
	Street Address	Street Address
		Annandale VA 22003
	City State Zip	City State Zip
		(571) 478- 1422
	Telephone Number	Telephone Number
	Fax Number	Fax Number
Feder permi contin	al Law Regulations and cannot be disclose tted in accordance with Federal Law Regu uity of care and to assist APWC and the a	t my/my child's records are protected under ed without my written consent unless otherwise alations. The purpose of this release is to provide ddressee in planning and providing services to bused to discriminate against me/my child or
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