THE PARKS CENTER
WOMEN'S WELLNESS AND MEDICINE

Medical Release Form

Patient Name: _____
Patient DOB: _____
Patient Phone #: _____
Patient Address: _____
_____

I, _____ authorize The Parks Center (Dr.Shannon Parks DO/Dr.Lauren Hollywood PMHNP-BC) to give and receive information concerning my medical and psychiatric care including treatment records and history to and from _____ at the below address.

Address: _____
_____

Patient Signature: _____
Date: _____
Witness Signature: _____
Date: _____

I, _____ authorize The Parks Center (Dr.Shannon Parks DO/ Dr.Lauren Hollywood PMHNP-BC) to give and receive information concerning my medical and psychiatric care including treatment records and history to and from _____
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