MAGIC CITY Wellness Center
A BAO Affiliated Program

MEDICAL RECORDS REQUEST

Patient Name:_____Date of Birth:_____
(legal name)
Telephone Number:_____Alternate Number:_____

Release to: Magic City Wellness Center
3220 5th Avenue South, Suite 100
Birmingham, AL 35222
Phone: 205.877.8677 Fax: 205.877.8675

Release from: Physicians Name:_____

Address:_____

Phone:_____Fax:_____ The

information being disclosed is for the purpose of continuing health care.

Please fax the information accordingly: healthcare covering the following
period(s): ☐ ALL ☐ from_____/_____/_____ to _____/_____/_____

I understand the specific information to be released may include alcohol or drug abuse, mental health or HIV status. _____(Initial Here)

Unless otherwise indicated, this authorization will expire one(1) year from the date of signature. The health care provider and employees are released from any legal responsibility or liability for the health care of the above information to the extent indicated or authorized herein. I understand that this authorization may be revoked in writing at any time, except to the extent for the action has been taken in reliance on this authorization for the purpose stated above.

Signature of patient or legal guardian_____

Relationship to patient:_____

Date:_____