



Medical Records Release Form

Client Name: _____

Address: _____

City, State, Zip: _____

Phone: _____ Email: _____

I authorize: **Pinpoint Acupuncture** (*a Division of Acupuncture & Natural Health, Inc*)

John Miley, L.Ac. (MN License #1129)

2177 Troop Drive, Sartell, MN 56377

Tel. 320-656-1010 Fax: 320-295-7517

(Check the items below that apply):

To release information to ...OR ...

To obtain information from...

Practitioner Name _____ Organization _____

Address: _____ City: _____

State/Zip: _____

Phone: _____ Fax: _____

Email: _____

Records requested include:

By signing below I attest that I have the legal right to release these records:

Printed Client Name: _____ Date: _____

Client Signature/Authorized Representative: _____

Relationship to Client: _____