



Records Release Authority

To: _____

Phone Number and/or location of specialist:

I _____ hereby request that
you release to:

Health & Wellness Institute

(Please Circle Physician Below)

Dr. John A. Catanzaro Dr. Carrie Miller Dr. Michael Corsilles

5603 230th St. S.W.

Mountlake Terrace, Wa 98043

Phone: 425.697.6112

Fax: 425.697.3252

all reports of my diagnosis, treatment, prognosis and recommendations, as well as other
data pertinent to your treatment of me.

Patient's Signature

Date of birth

Witness Signature

Date of request