



Delmar Wellness Center

www.delmarwellness.com

Acupuncture · Chiropractic · Massage · Therapeutic Nutrition
Weight Management · Detoxification · Medicinal Herbs

Request & Authorization for Medical Records

Confidentiality Notice: This facsimile may include patient information which should be considered private, confidential, and/or exempt from disclosure under HIPPA law. If you have received this message in error, please immediately shred and notify The Delmar Wellness Center or Dr. Olejak. You are hereby notified that any disclosure, copying, distribution, or use of the information contained herein (including any reliance thereon) is STRICTLY PROHIBITED. Thank you for your cooperation.

To whom it may concern:

I, _____ (PRINT NAME), hereby authorize you to disclose the following records to Delmar Wellness Center (Dr. Olejak). Whenever requested to do so please release the following records related to my case file.

(✓ check all boxes that apply)

Diagnostic Imaging

Lab Reports

Treatment Procedures

Health History

Accident reports

Name and Telephone of Records Location

A photocopy / fax of this authorization form shall be as effective and valid as the original on file with Dr. Olejak

This authorization is not a release on any claim I may have.

Patient Name (signature)

Date

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