Jakob Sletteland MSc, RH(AHG)
Consent for the Release of Information

I hereby authorize Jakob Sletteland MSc, RH(AHG) at Vital Force Natural Health, The People's Wellness Center, 71 Centennial Loop, Suite B, Eugene, OR 97401

To Obtain From:

Name/ address/ phone required:

My records dated from_____to _____

Include the following within the above dates:

_____Initial Assessment_____Progress Notes _____Discharge Summary

_____Laboratory Tests _____Office Notes _____History & Physical

_____Other_____

I DO EXPRESSLY AND VOLUNTARILY AUTHORIZE THE DISCLOSURE OF THE SAID MEDICAL RECORDS TO THE PERSON(S) AND / OR ENTITIES AS STATED ABOVE. I UNDERSTAND THAT THIS CONSENT CAN BE REVOKED AT ANY TIME BY LETTER, EXCEPT TO THE *EXTENT* THAT ACTION HAS ALREADY BEEN TAKEN, AND THAT THIS CONSENT WILL REMAIN IN EFFECT NO LONGER THAN THE TIME REASONABLY NECESSARY TO ACCOMPLISH THE PURPOSES FOR WHICH IT IS GIVEN.

Client Name_____Client Signature_____Date____

Practitioner Name_____Practitioner Signature_____Date____

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