Medical Records Release

Please complete the following information.

I, _____, hereby authorize **New Vision Wilderness**, to release verbal and written Information and documentation pertaining to the placement and treatment of the following client: _____ to _____ at _____.

The information specifically being requested is checked below:

☐Academic Records	☐Medical Appointments	☐Supplementary Assessments
☐Discharge Information	☐Medication Records	☐Treatment Plan
☐Education Log	☐Progress Notes	☐Other _____
☐Intake Packet	☐Psychiatric Visits	

By signing, I am agreeing to the release of all pertinent information concerning the care, treatment and progress at New Vision Wilderness, as well as well as insurance documentation and billing (if applicable).

This release will be effective for one year unless otherwise noted:_____.

_____ Signature

_____ Relationship

_____ Date

Please email, mail, or fax this form to: NVW
Medical Records
PO Box 1810
Lake Ozark, MO 65049-1810
Fax: 573-365-2224
Email: UR@caloprograms.com