

Patient Name _____ Date of Birth _____

I authorize DLS to release health information electronically (email or fax) or paper to:
Wellness Alternatives – David Peterson, DC

Name of person or facility to receive health information

266 Lamp and Lantern Village Town and Country, MO 63017

Street Address, City, State, Zip

636-227-4949

Phone

636-779-1456

Fax

dpeterson@wellnessalternatives-stl.com

Email

INFORMATION TO BE RELEASED

Laboratory Report(s) Date of Report _____

Requisition Number _____

Billing Statements

SIGNATURE

(Signature of Patient or Patient's legal representative)

Date _____

Printed Name _____