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**AUTHORIZATION FOR DISCLOSURE
GENERAL CONSENT FORM**

I, _____
Name Birth date SS#

Authorize **ANY MEDICAL PROVIDER**

To Disclose To **THE WULF CLINIC**
Or authorized representative, providing ID verification.

THE FOLLOWING INFORMATION FROM MY CLIENT FILE OR RECORDS:

1. Client information and services provided (types and dates only).
2. Summary of Assessment and Treatment.
3. Physical examinations or other medical information.
4. ANY Radiology reports and films needed for diagnosing or treating.

The purpose for disclosure is records review. The consent to disclose information from my records may be revoked by me or anyone holding power of attorney if such is among the enumerated powers, at any time, except to the extent that the consent has been relied on and action has been taken thereon.

This consent becomes effective on the date that it is signed. This information will be released ONLY to the person or organization above named. It will not be disseminated to anyone, for any purpose, other than the one specified.

Client Signature: _____

Date: _____

Witness signature: _____

Date: _____