EPIC WELLNESS
Workplace Health Solutions

Medical Information Release Form

Name: _____ Date of Birth: _____

Please select one of the boxes below.

☐ I authorize Epic Wellness to release information including my name, date of services and amount owed to the company listed below. ***NO OTHER*** medical information will be released. The information outlined above may be released to:

STATE OF VERMONT

☐ Information is NOT to be released to anyone. I understand by checking this box that I will not be able to take advantage of my company's paid offerings with Epic Wellness.

This Release of Information will remain in effect until terminated by me in writing.

Signed: _____ Date: _____