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Charlotte, NC 28226
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To Whom This May Concern,

I, _____, do hereby grant permission to all of the physicians of Elev8 MD Wellness Center to discuss the treatment I have received from them as well as to receive information regarding all care that I have received from the provider listed below:

Provider Name:

Address:

Contact Phone Number:

Signature of Patient

Date of Birth: _____

Printed Name of Patient