# Patient Referral

Date:

Patient Name: _____ DOB: _____

Patient Phone: (  )  -  Email: _____

Referring Practitioner: _____

Practitioner Phone: (  )  -  Email: _____

Name and preferred contact of Practitioner's office representative:

_____

Patient is being referred for Lifestyle Therapy with special attention to:

☐ Fitness ☐ Nutrition ☐ Stress Relief

Practitioner's notes: _____

_____

_____

_____

In an attempt to reduce unwanted spam from online, please call or text 916-482-8282 for our email address to scan and send this form to, along with a signed patient information release (use the one attached or your own) so that we may share any information regarding treatment with you.

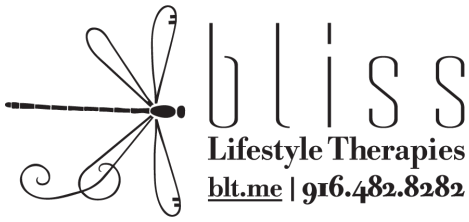
Please contact us if you have any questions.

Thank you,

Bliss Lifestyle Therapies Team

bliss
Lifestyle Therapies
blt.me | 916.482.8282

## Patient Information Release




Effective date: _____

Patient Name: _____ DOB: _____

Address: _____
*street address, city, state, zip*

I authorize _____ (practitioner's office), and Bliss Lifestyle Therapies to exchange my confidential health information necessary to effectively provide care, and for no other purposes.

I understand that signing this form is voluntary, and that I can revoke this permission at any time by providing a written notice of revocation to either of the afore mentioned offices. The revocation will be effective immediately upon the health care provider's receipt of my written notice, except in that it will not have any effect on any action of the health care provider(s) regarding information released prior to the receipt of written notice of revocation.

Name: _____Date: _____
*Print*

Signature: _____

Receiving office : _____Date: _____

Representative: _____
*Print*

Signature: _____