RECORD RELEASE AUTHORIZATION

DOCTOR / HOSPITAL _____

ADDRESS _____

_____

_____

I HEREBY AUTHORIZE AND REQUEST THE RELEASE OF MY MEDICAL RECORDS TO:

THANK YOU IN ADVANCE FOR YOUR COOPERATION.

_____ _____
Patient's Signature Date

_____
Patient's Name (Please Print)

_____ _____
If Patient Is A Minor Signature Of Parent Or Legal Guardian Relationship to Patient

_____ _____
Witness To The Above Signatures Please Print Name