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MEDICAL RECORDS RELEASE

Patient's Name: _____Date of Birth_____

Address: _____Phone: _____

I request and authorize the release of medical records of the named above to:

Doctor/Company: _____

Address: _____

Phone: _____Fax: _____

This request and authorization applies to:

_____Health care information relating to the following treatment, condition or date of treatment.
_____

_____All Health care information

_____Other: _____

This authorization will expire one year from the date below unless otherwise stated in writing.

_____ Date_____
Signature of patient or guardian