AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I hereby request and authorize the release of all information, without limitations, regarding any physical and mental condition, as revealed by your observation or treatment, past, present, or future.

This includes medical history, diagnosis, prognosis, laboratory work, pathology reports and access to all hospital records and photocopies of the same.

I request that you release the above information to:

Name of the Patient or Subsequent Doctor

Address

City State Zip

Patient's Signature Patient's DOB Date

Print Name

Witness's Signature Date

Print Name

For Office Use:
Copy of Records Mailed

Name of Person Mailing Records Date