AUTHORIZATION TO RELEASE INFORMATION

To: _____

Address: _____

Phone: _____Fax: _____

I, _____ D.O.B. _____ request the following information:
(Patients Name)

___History ___Records ___Diagnosis ___Reports ___Treatment

Concerning my: ___Illness ___Accident ___Injury ___Other_____

To be released to: _____

For the purpose of : _____

I understand that I have a right to receive a copy of this authorization upon my request.

Signature: _____ Date: _____
__Patient __Spouse __Parent __Guardian

Dr. Signature: _____ Date: _____