AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

TO:

Patient Name ___________________________________

Social Security # _________________________________

Date Of Birth ____________________________________

This authorization to release medical information is being requested of you in compliance with the general terms of the confidentiality of medical information.

By my signature below, I authorize you to discuss or release all information, including medical records, x-rays, history, and findings and prognosis pertaining to my medical condition, services rendered me, or treatment given me to:

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Limitations on discussion and release, if any:

This authorization shall remain in effect for one year or until canceled in writing.

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Signature of patient/parent/conservator/guardian/ or patient's representative