RECORDS RELEASE AUTHORIZATION

TO: _____

ADDRESS: _____

I HEREBY AUHTORIZE AND REQUEST YOU TO RELEASE TO:

DR. _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____

THE COMPLETE HISTORY RECORDS IN YOUR POSSESSION, CONCERNING MY ILLNESS AND OR TREATMENT DURING THE PERIOD FROM _____ TO _____

NAME: _____ Date: _____

Address: _____

Signature: _____ Witness: _____
(if relative, state relationship)