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RECORDS RELEASE AUTHORIZATION

_____
(Physician, Hospital or Clinic name)

_____
(Address, City, State and Zip code)

_____
(Office Telephone Number) *(Fax Number)*

I, _____, hereby authorize and request the release of any and all medical records in your possession, concerning my medical history.

☐ FROM_____TO_____

☐ ALL MEDICAL RECORDS

*Notes*_____

_____
Last Name First Name MI

_____
Home Address City, State and Zip

_____ _____
Date of Birth Social Security Number

_____ _____
Signature Date Records Requested