

MEDICAL RECORDS RELEASE AUTHORIZATION

DATE: _____

PATIENT'S

NAME: _____

SS#: _____

DOB: _____

I hereby authorize and direct you to release medical records relative to my illness and/or treatment as described below:

Records pertaining to dates of services
from _____
Records pertaining to specific dates as listed

Other,
Specify: _____

SEND INFORMATION TO:

Signature of Patient or Legal Representative/Relationship

Witness: _____

This authorization expires on _____
