AUTHORIZATION FOR RELEASE OF CASE RECORDS

Patient's Name:_____

Patient's
Address:_____

Patient's
DOB:_____

INFORMATION REQUESTED

[ ] Medical Records

[ ] X-rays

[ ] Medical Records and X-rays

[ ] Other: _____

AUTHORIZATION

I hereby authorize _____to disclose to

_____ or their agent any information

which he may have acquired by examination or other means of my physical or mental

condition; and I hereby release him of any consequence thereof.

Dated at _____this _____day of _____, 20 _____

_____ _____

Signature of Witness Signature of Patient