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:

____

____

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____

Signature of Patient or Legal Representative/Relationship

Witness:________________________________

This authorization expires on_______________________