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MEDICAL RECORDS RELEASE AUTHORIZATION

Please complete the following information:

Patient name:_____DOB: _____

Address: _____

City: _____State: _____ Zip Code: _____

Phone: _____

I, _____, authorize the release of the following records (please select):

    __ Office Notes   __ Laboratory/ Pathology Records

    __ Billing Records   __ Other (specify)

These records are for services provided on the following dates: From: (Year) _____ to (year) _____

Please send records to :

Name: _____

Address: _____

City: _____   State: _____ Zip Code: _____

Phone: _____   Fax: _____

Patient's Signature: _____   **Date:** _____