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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Date _____

Patient Name _____

Date of Birth _____ Phone Number_____

From: Current Physician _____

Please release all of my medical records for all treatment received by you or under your supervision. This information will be used to further assist in my medical care, and should be sent to:

To: New Physician Name _____

Address _____

_____

Phone Number _____ Fax Number _____

I authorize and request that any and all Medical Information as indicated above be released according to the terms outlined in this agreement.

Signature of Patient or Guardian _____

Print Name/Relationship to Patient _____

Date of Request _____

Witness Signature _____

(We do reserve the right to charge for this service)