

MEDICAL AUTHORIZATION  
RELEASE OF MEDICAL RECORDS

You are hereby authorized to release any and all information, records and reports for medical and/or hospital care given to me. Release of said information is to be made to:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Thank You,

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Date: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Patient Signature: \_\_\_\_\_