



RECORDS RELEASE

Date of Request _____

My permission is granted to Dr. _____

To disclose to _____
 complete information concerning the medical findings and treatment of:

_____ PATIENT

From _____ to _____
 DATE DATE

I release Dr. _____
 From any laws related to disclosure of confidential or privileged information.

Signature _____
 PATIENT OR PERSON AUTHORIZED TO CONSENT FOR PATIENT

Address _____

Witness _____ Date _____