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AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORDS

PATIENT'S NAME **DATE OF BIRTH**

Please indicate below any specific records needed or check ALL:

☐ All

☐ Other _____
Please list dates of the report that you want

_____

I do hereby authorize_____to release my medical records to:

_____

_____

_____

_____

I understand that I may revoke this consent at any time by giving written notice to the Medical Records Department of the facility listed above. If no prior notice of revocation is received, this consent will expire automatically thirty (30) days after the date indicated below.

PATIENT SIGNATURE_____DATE_____