

## AUTHORIZATION TO RELEASE MEDICAL RECORDS

I hereby request and authorize \_\_\_\_\_ to release my entire medical/personal records to the party/parties listed below. This information may include, but may not be limited to, medical history, physical findings, treatments, reports and recommendations. I understand that my medical records might include third party reports or consultations that were made or received on my behalf, as well as any psychiatric, drug and/or alcohol related information, if applicable. There may be administration charges applicable so please consult the releasing party prior to contacting them with this form.

Please Release My Records To:

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\_\_\_\_\_  
PATIENT NAME

\_\_\_\_\_  
D.O.B.

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
WITNESS

\_\_\_\_\_  
DATE