AUTHORIZATION FOR RELEASE OF RECORDS

I hereby authorize you to release my individual health information to:

_____

_____

_____

_____

Any information including the diagnosis and records of any treatment rendered to me during the period from _____ to _____.

Patient/Patient Representative Signature_____

Patient/Patient Representative Printed Name_____

If patient representative, please state the relationship to patient_____

Date Signed_____

Comments:_____

_____