

RECORDS RELEASE AUTHORIZATION

To _____
DOCTOR OR HOSPITAL

ADDRESS

I HEREBY AUTHORIZE AND REQUEST YOU TO RELEASE TO:

THE COMPLETE HISTORY RECORDS IN YOUR POSSESSION, CONCERNING MY
ILLNESS AND/OR TREATMENT DURING THE PERIOD FROM _____

TO _____

NAME _____ DATE _____

ADDRESS _____

SIGNATURE _____ WITNESS _____
(IF RELATIVE, STATE RELATIONSHIP)