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RECORDS RELEASE AUTHORIZATION

I, _____, give permission to the following
(Patient's Name or Guardian)
person(s) to have access to my complete medical records:

- 1. _____ Relationship: _____
- 2. _____ Relationship: _____
- 3. _____ Relationship: _____
- 4. _____ Relationship: _____

This includes a report of the diagnosis, treatment, prognosis and recommendations, as well as other data pertinent in the treatment of myself.

Patient Signature

Date

Patient's Printed Name

Patient's Date of Birth

Patient's Social Security Number