

AUTHORIZATION

I hereby authorize _____

to release to _____

all health records concerning me.

I waive any and all claims in connection with the communication and disclosure of such information.

Signed this _____ day of _____ of _____.

Signature

Social Security Number

Printed name

Date of Birth

Signature of witness

DO NOT WRITE BELOW THIS LINE

Sent to: _____

Date: _____

Fax number: _____

Mailed to: _____

Sent by: _____

