AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

To [Title8],

You are authorized to release to [Title9], any and all medical records related to treatment I may have received from [Title10] [Title11], [Title12] to [Title13] [Title14], [Title15]. A photocopy of this authorization shall have the same force and effect as an original.

All prior authorizations are cancelled.

Dated: DATE

_____
[Title] [Title1] [Title2], [Title3]
[Title4]

Date of Birth: [Title5] [Title6], [Title7]