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RECORDS RELEASE AUTHORIZATION

Date: _____

Please release my medical records to:

_____

_____

_____

☐ The Operative Report for (type) _____ surgery.

☐ Only the following portion of my records _____

_____.

☐ The complete history of records in your possession concerning my illness and/or treatment (or my childs illness and/or treatment, in the case of a minor) during the period from _____ to _____.

My name at that time was: _____
(Please Print)

My name now is: _____
(Please Print)

Date of Birth: _____ **S.S. #:** _____

Signature: _____