## AUTHORIZATION FOR RELEASE OF RECORDS

| **OBTAIN FROM:** | **SEND OR FAX TO:** |
|---|---|
| ______________________ Physician/Institution | ______________________ Physician/Institution |
| ______________________ Address | ______________________ Address |
| ______________________ City State Zip | ______________________ City State Zip |
| ______________________ Phone Fax | ______________________ Phone Fax |

I give my authorization for these records to be released. This request is a free and voluntary act by me.

| | |
|---|---|
| ______________________ (Signature of patient or legal representative) | ______________________ Patient Name |
| ______________________ (Printed name of patient or legal representative) | ______________________ (Date) |

Specific Information Requested

| | |
|---|---|
| __________ History & Physical | __________ Lab Reports |
| __________ Progress Notes | __________ X-ray Reports |
| __________ Operative Report | __________ Pathology Reports |

__________ Other (please specify) ______________________________