

RECORDS RELEASE AUTHORIZATION

TO _____
Doctor, Clinic or Hospital

ADDRESS _____
City State Zip Code

I HEARBY AUTHORIZE AND REQUEST YOU TO RELEASE TO:

All records for _____ in your possession concerning _____
_____ illness, diagnosis and/or treatment,
prognosis and recommendations during the period from _____ to _____

NAME _____ TEL _____
(If a minor, parent or guardian's name)

ADDRESS _____
City State Zip Code

SIGNATURE _____ Request Date _____

WITNESS _____ DATE _____

FEES: The fee for copying records is \$15.00. State and federal laws specify a reasonable charge to offset the cost associated with the reproduction of records. There is no fee for reproducing and forwarding records to referring physicians currently involved with patient's continuing care.