AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

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(Organization to release records)

I, the undersigned patient or guardian below, hereby authorize the release and furnishing of medical records regarding the following patient:

_____________________________________ _____________ ,
(Name of patient) *(Date of birth)*

to the following individual or organization:

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(Recipient of records)

I further understand these records may contain information from other health care providers as well as administrative dates which are not strictly medical in nature. I release you from all responsibility and liability that may arise from this authorization.

_____________________________________ _____________
(Signature of patient or legal guardian) *(Date)*

_____________________________________ _____________
(Signature of witness) *(Date)*