



**Authorization for the Release of Medical Records**  
**\*\*\*Must Present Photo ID of Patient\*\*\***

**Patient's Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Requesting records from:**

**Doctor/Facility Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**City, State, Zip Code:** \_\_\_\_\_

**Release records to:** \_\_\_\_\_

**Doctor/Facility Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**City, State, Zip Code:** \_\_\_\_\_

**Please release any/all information including diagnosis, examination, and treatment unless specified otherwise below.**

**Treated for:** \_\_\_\_\_

**Dates of Service:** \_\_\_\_\_

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**DOB**

\_\_\_\_\_  
**Witness**

\_\_\_\_\_  
**Photo ID Verified:**