## **RECORD RELEASE AUTHORIZATION**

DOCTOR / HOSPITAL	
ADDRESS	
I HEREBY AUTHORIZE AND REQUEST THE RELEAS RECORDS TO:	E OF MY MEDICAL
THANK YOU IN ADVANCE FOR YOUR COOPERATION.	
Patient's Signature	Date
Patient's Name (Please Print)	
If Patient Is A Minor Signature Of Parent Or Legal Guardian	Relationship to Patient
Witness To The Above Signatures	Please Print Name