

**RECORDS RELEASE**

Date \_\_\_\_\_

To \_\_\_\_\_

I hereby authorize you to release to:

\_\_\_\_\_  
\_\_\_\_\_

any information including ALL diagnosis and records of any treatment or examination rendered to me.

Print or type name \_\_\_\_\_

Signature \_\_\_\_\_

SS# and DOB \_\_\_\_\_

Witness Signature \_\_\_\_\_