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RECORDS RELEASE

Date _____

To:

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I hereby authorize you to release to:

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

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the individual or organization releasing the information. I understand that the revocation will not apply to information already released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____ . If I fail to specify an expiration date, event or condition, this authorization will expire in six (6) months.

Print or type name: _____

Signature: _____

SS# and DOB: _____

Witness Signature: _____