

Authorization to Release Information

Regarding: _____

To whom it may concern:

You are hereby authorized and requested to permit _____
or authorized agent to view and obtain copies of any and all records or information
written or otherwise that you may have pertaining to diagnosis, treatment, medical
history, prescriptions, or prognosis of the medical condition of the above named party as
that information relates to any and all injuries, illnesses, disabilities, or physical or
psychiatric conditions, and to permit the sender or bearer of this authorization to discuss
said information with you and review any records.

A photocopy of this signed document may be used in lieu of the original.

Signature _____ Date _____

Witness _____ Date _____