AUTHORIZATION FOR RELEASE OF MEDICAL/DENTAL RECORDS

I hereby request and authorize the release of all information, without limitations regarding and physical and mental condition, as revealed by your observation or treatment, past, present or future.

This includes medical/dental history, x-ray finding, diagnosis, prognosis, and access to all hospital records and photocopies of the same.

I request that you release the above information to:

_____

_____

_____

_____

_____

Patient's (or Legal Guardian's) Signature Date

_____

Witness' Signature Date