AUTHORIZATION FOR RELEASE OF RECORDS

Obtain From:	**Send or Fax to:**
______________________ Physician/Institution	______________________ Physician/Institution
______________________ Address	______________________ Address
______________________ City State Zip	______________________ City State Zip
______________________ Phone Fax	______________________ Phone Fax

I give my authorization for these records to be released. This request is a free and voluntary act by me.

______________________	______________________
(Signature of patient or legal representative)	Patient Name
______________________	______________________
(Printed name of patient or legal representative)	(Date)

Specific Information Requested

___________ History & Physical

___________ Progress Notes

___________ Operative Report

___________ Other (please specify)

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__________ Lab Reports

__________ X-ray Reports

__________ Pathology Reports