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Date: _____

This is to authorize:

_____

(Name of Facility and Physician)

_____

(Address) *(City)* *(State)*

To release to:

_____

(Name of Facility and Physician)

_____

(Address) *(City)* *(State)*

any and all information from the medical record or my hospitalization and treatment rendered me during the period from _____to _____. information released will be considered confidential.

Patient's Date of Birth:

_____

Patient's Name:

_____

Patient or Guardian Signature:

_____

Witness Signature:

_____