

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Date:

To:

I hereby authorize and request that you release and deliver to:

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all my medical records, charts, files, prognoses, reports, x-rays, laboratory reports, clinical records, and such other information relative to my medical condition or my treatment at any time provided to me and all to the extent said information is available and within your possession. You may bill me for any costs. You are further requested not to disclose any information concerning my past or present medical condition to any other person without my express written permission.

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Signature

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Printed Name

## Acknowledgment Certificate

State of \_\_\_\_\_

County of \_\_\_\_\_

On this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_,  
*Month* *Year*

\_\_\_\_\_  
*Printed Name of Signer*

Personally appeared before me as the signer(s) of the attached instrument, and  
he/she/they signed the instrument voluntarily for the purpose expressed in it.

Witness my hand and official seal.

\_\_\_\_\_  
Signature of Notary

\_\_\_\_\_  
Notary's Name, County, Commission Expiration Date

Signer's identity verified in the following manner:

\_\_\_\_\_ Personally Known

\_\_\_\_\_ Produced Identification