

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

TO WHOM IT MAY CONCERN

You are authorized to release to: \_\_\_\_\_, any  
and all medical records related to treatment which I may had on  
the following approximate dates:

\_\_\_\_\_

A photocopy of this authorization shall have the same force and  
effect as an original.

\_\_\_\_\_

\_\_\_\_\_

Social Security Number: \_\_\_\_\_

Date of birth: \_\_\_\_\_