Request for Release of Records:

Name of Patient: _____

Date of Birth: _____

I hereby authorize:_____
(Name of doctor, school, hospital or individual releasing information)

To release to: _____
(Name of doctor, school, hospital or individual receiving information)

The following information: _____

Covering the time period from: _____

This information will be used for diagnostic purposes. I further understand I may revoke the consent at any time except to the extent that action has already been taken on it and it will expire automatically in 90 days form the date below.
The doctor, hospital, individual or dental school releasing authorized information is hereby relieved from all legal responsibility or liability for the release of the information described above to the extent indicated and authorized herein.

_____ _____
(Date) (Signature of Patient or Parent/Guardian)

_____
(Signature of witness)

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