

AUTHORIZATION FOR MEDICAL INFORMATION

Date

This will authorize you to disclose to
or its representative, any and all information you may have regarding my condition while under
your observation or treatment at any time, including medical history and findings; consultation,
prescriptions, treatment, x-ray, special consultation reports, diagnosis and prognosis, and copies of
all hospital and medical records.

Print Name

Signed.....

Witness:

Print Name

Signed.....