AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

FROM:

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Information to be Released to:

Name_____

Address:_____

_____

INFORMATION TO BE USED FOR:

_____CONTINUED CARE TO ANOTHER DOCTOR

No charge for first Doctor. $15 for each additional Doctor.

_____PERSONAL USE. $ 25

NAME_____

ADDRESS:

_____

_____

CITY. STATE ZIP CODE

PATIENT CELL PHONE : ( ) _____

PATIENT E-MAIL:_____

BIRTHDATE:_____/_____/_____

SIGNATURE:_____ DATE_____