AUTHORIZATION FOR RELEASE OF INFORMATION

I hearby authorize ___All Healthcare Providers (or specify below) to release the following information in my records to **Dr.** _____

[ ] Records of outpatient treatment
[ ] Records of hospitalization and inpatient treatment
[ ] All diagnostic and laboratories
[ ] Other_____

I understand that I have the right to revoke consent to future disclosure in writing at any time.

_____ _____

Signature of Patient Date