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.....