

SAMPLE
Release of Medical Information

Date: _____

To: _____

Patient's Name: _____

Date of Birth: _____

Other Identifying Information:

I hereby authorize _____

*to **RELEASE** such information as may be necessary for medical attention.*

Patient's Signature

Authorization must be signed by patient or nearest relative or guardian in case of minor, or when the patient is physically or mentally incompetent.

Relative or Guardian's Signature