

AUTHORITY TO RELEASE
MEDICAL AND/OR HOSPITAL RECORDS

To: _____ Address: _____

Patient: _____ Address: _____ Age: _____

You are hereby authorized to furnish and release to my attorney, _____, _____, all information and records he requests concerning findings, treatment rendered, and opinions as to my condition, including records of any attempted suicide, abuse of drugs or alcohol, and pathological examination of tissue removed. Please do not disclose information to insurance adjusters or other persons without written authority from me (pursuant to confidential and privileged communications laws). All prior authorizations are hereby canceled, and I waive any privilege I have to my said attorney. The foregoing authority shall continue in force until revoked by me in writing, but no longer than one year from the below date. This information is necessary for my said attorney to represent me in regard to my injuries.

_____, 19____

X _____
Patient (if minor, adult with authority to act;
if patient deceased, legal representative)

Witness

Witness

TO DOCTOR OR HOSPITAL RECORD LIBRARIAN: PLEASE READ THE UNDERSIGNED FOR RECORDS DESIRED.

I respectfully request the following:

- _____ Itemized bill for services (in duplicate)
- _____ Medical report (in duplicate)
- _____ Complete hospital record
- _____ Hospital record (without nurse's notes)
- _____ Abstract of hospital records
- _____ Reports of all notes of surgical procedures

- _____ First aid report only
- _____ X-ray reports
- _____ X-ray films
- _____ Positive copies of X-ray films
- _____ Laboratory reports
- _____ Advise if any prior admissions or treatment

Please attach your invoice for any photostatic cost and send with request records to my office.

Approximate date(s) service rendered _____

_____ 19 _____

Thank you,

Attorney at Law

