AUTHORITY TO RELEASE
MEDICAL AND/OR HOSPITAL RECORDS

To: _____ Address: _____

Patient: _____ Address: _____

You are hereby authorized to furnish and release to my attorney, _____, _____(*address, telephone no.*)_____. 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 cancelled, 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.

_____, 20____ 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 nurses/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

Approximate date(s) service rendered
_____
_____
_____20_____

Thank you,

_____
Attorney-at-Law
_____
_____