AUTHORIZATION FOR DISCLOSURE OF MEDICAL RECORDS

I, , (S. S. #) born in in and currently residing at , , hereby consent to the disclosure of information from my records by and any and all attending physicians for treatment occurring during .

I authorize the above person or entity to disclose any and all of these medical records, including but not limited to:

1. Hospital records, charts and files including, but not limited to, admission and discharge sheets, summaries, reports and instructions, histories, examinations, consultations, testings, physical therapies, diagnoses, photographs, radiology reports (including any and all CAT Scans, ultrasounds, x-rays, MRI's, Myelograms and written reports), operative reports, pathology reports, laboratory reports, progress notes, nurses' notes, orders, correspondence and bills for service.

2. Physicians' office records, files and correspondence, including, but limited to, admission and discharge sheets, summaries, reports and instructions, histories, examinations, consultations, tests, treatments, diagnoses, photographs, radiology reports and bills for service.

This disclosure is to be made to , , or his/her authorized representative.

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Date Consent Signed

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