



Buckeye Health & Rehabilitation

RECORD RELEASE AUTHORIZATION

Patient Name: _____

Date of Birth: _____ **Social Security No.:** _____

Doctor / Hospital _____

Address _____

Phone _____

To Whom It May Concern:

You are hereby requested and authorized to disclose, make available and furnish to

_____ ,

my authorized representative, all information, records, x-rays, reports or copies thereof relating to my examination, consultation, confinement or treatment, and to permit him to inspect and make copies or abstracts thereof.

THANK YOU IN ADVANCE FOR YOUR COOPERATION.

Patient's Signature

Date

Patient's Name (Please Print)

If Patient Is A Minor Signature Of Parent Or Legal Guardian

Relationship to Patient

Witness To The Above Signatures

Please Print Name