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Authorization to Release Medical Records

Date: _____

Fax: _____ Tel: _____

I hereby authorize and request _____
(provider/facility)
to release my medical record, include but not limited to
□ Labs □ X-rays □ MRI □ CT □ All records □ Others _____

To Dr. □ Xin Wang, □ Nan Jiang, □ Juliette Depue, □ Jeniffer Farrell

Patient Name: _____ Date: _____
(Print)

Patient Signature: _____ Date of Birth: _____

Witness Name: _____ Date: _____
(Print)

Witness Signature: _____