MEDICAL RELEASE

To whom it may concern:

I hereby authorize you to furnish to my insurance company, or any other treating physician or attorney, (if you are using an attorney for your treatment), any and all information regarding any physical condition, injury, illness or disease regarding which I have consulted you or received your services, within the last (5) years, including the nature of any physical impairment, history, or contributing factors, complications, prescriptions, x-rays, hospital and medical reports, any applications for insurance, periods of disability, subjective symptoms, objective symptoms, diagnosis, prognosis, the result of any HIV antibody testing and any further information that may be available to you.
A photo static copy of this authorization shall serve in its stead.

___________________________________ _______________

Name **D.O.B.**

____________________________________ ____________ __________ __________

Address **City** **State** **Zip**

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Signature