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**Release of Records Authorization**

\_\_\_\_\_ Born: \_\_\_\_\_, hereby authorizes and  
(Name of Patient)

request the release of the following:

- |       |                |       |                    |
|-------|----------------|-------|--------------------|
| _____ | Progress Notes | _____ | Laboratory results |
| _____ | X-Ray reports  | _____ | Skin Testing       |
| _____ | PFT reports    | _____ | All health records |

Authorization given to:

To release to:

_____	_____
_____	_____
_____	_____
_____	_____

I understand that I have the right to read and/or copy the information to be disclosed for the required fee. I also understand that I have the right to revoke this consent by written statement at any time, otherwise it will automatically expire 90 days from the date of authorization. I understand that information will not be released if I refuse to sign this form.

\_\_\_\_\_  
(Signature of patient or legal representative)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Relationship to patient)