I M S
INTERNAL MEDICINE SPECIALISTS

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AUTHORIZATION TO RELEASE MEDICAL RECORDS

I, _____, hereby give permission to Internal Medicine Specialists to release my information to the following:

NAME: _____

RELATIONSHIP TO PATIENT: _____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

NAME: _____

RELATIONSHIP TO PATIENT: _____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

NAME: _____

RELATIONSHIP TO PATIENT: _____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

I fully understand that I can revoke this authorization at any time.

PATIENT'S NAME: _____

_____ _____

PATIENT'S SIGNATURE **DATE**