

**AUTHORIZATION FOR MEDICAL AND HOSPITAL
RECORDS AND REPORTS**

To whom it may concern:

This will authorize you to give the bearer of this document all information you may have, without limitation, regarding my physical condition as revealed by your observation or treatment past, present, and future. This includes history, findings, X-rays, diagnosis, prognosis and access to hospital records for examination and photocopying.

This authorization extends to any party who has medical information concerning my physical condition past, present and future. The authorization, therefore, specifically includes any physician who has examined and/or treated me and any hospital where I have been examined and/or treated. Furthermore, the medical information includes information regarding psychiatric treatment, substance and/or alcohol abuse treatment.

It also applies to present and prior employers and any insurance carrier who may have records of my physical condition.

I am willing that a photocopy of this authorization be accepted with same authority as an original.

(Signed) _____ DATE _____

(Print Name) _____

Date of Birth: _____