

MEDICAL RECORDS RELEASE

Date: _____

To:

Doctor or Hospital

Address: _____

City, State, Zip: _____

I hereby authorize and request you to release to Kevin D. Nolan, M.D. and/or William F. Oppat, M.D. and/or Tamer N. Boules, M.D. and/or Pritham P. Reddy, M.D. at the above address, my complete medical record in your possession concerning my illness and / or treatment during the period from _____ to _____.

Signed: _____

Patient's signature

Witness: _____

Relationship: _____