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PATIENT AUTHORIZATION FOR RECORDS RELEASE

Patient's name: _____

Patient's Social Security #: _____

I hereby request and give my permission for the release of information and records in my file at Dr. Bayley's office, including x-rays, as indicated below:

Items: Current x-rays

Other: _____

I acknowledge personal receipt of the above (initial) _____

Please forward records to: _____

_____

_____

Signed: _____

(Patient or parent/guardian if under 18)

Date: _____

Office staff initials: _____

(Thank you. This form is used as a means of preserving confidentiality and guardianship of the records. If we can be of any other help, please call).