



AUTHORIZATION FOR RELEASE OF RECORDS

To	
(Doctor or Hospital)	
(Fax Number	er)
I hereby authorize and request you	to release to Dimensional Health at 112 E.
Queenwood, Morton, IL 61550,	Fax: (309)263-1117
	in your possession concerning
(Patient Name)	(Date of Birth)
Date	
Signature of Patient	