Merle F. Bruce, M.D.
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Authorization for Release of
Protected Health Information

I ____(Patient First, Middle, Last Name)

____(Patient DOB)

authorize Merle F. Bruce, M.D. to disclose and release my complete medical records on file

to:
Name and Address:

____

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This information may be used by the person/Doctor I authorize to receive this information for medical treatment or consultation or other purposes as I may direct.

This authorization shall be in force as of __________________________________(Date)

Patient Signature (or Patient representative)

____

Patient Printed Name____

Date______________________________