

AUTHORIZATION FOR RELEASE OF RECORDS

To _____
(Doctor or Hospital)

(Fax Number)

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

Signature of Witness