

RECORDS RELEASE AUTHORIZATION

**THE FLOWERS CLINIC
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Date: _____

Please release my medical records to:

The complete history records in your possession concerning my illness and/or treatment (or my child's illness and/or treatment, in the case of a minor) during the period from _____ to _____.

The operative report, for (type) _____ surgery.

Only the following portion of my records _____

My name at that time was: _____
(Please Print)

My name now is: _____
(Please Print)

Signature: _____

S.S. #: _____ **Date Of Birth:** _____