

**AUTHORIZATION TO FURNISH MEDICAL INFORMATION**



To whom it may concern: this will authorize you to give the bearer of this document all information you may have, without limitation, regarding my physical and mental condition as revealed by your observation or treatment past, present and future. This includes history, findings, x-rays, diagnosis, prognosis and access to hospital records for examination and photocopying. I am willing that a photocopy of this authorization be accepted with the same authority as the original.

Signed \_\_\_\_\_ Date \_\_\_\_\_

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