

## Form - Medical Authorization

Patient's Name \_\_\_\_\_

Social Security Number \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_

Phone Number \_\_\_\_\_

By my signature below, I hereby authorize and request \_\_\_\_\_ (*Name and Address of Hospital or Other Institution*) \_\_\_\_\_ provide \_\_\_\_\_ (*Law Firm*) \_\_\_\_\_ with access to all my medical records and copies thereof as may be requested pertaining to my stay and treatment from \_\_\_\_\_ to \_\_\_\_\_ (if no limitation is preferred, so state) including any treatment for alcohol and drug abuse.

I request that this authorization remain valid until further notice from me.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Signature of Parent, Guardian, or Authorized Representative (Relationship)

\_\_\_\_\_