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Authorization to release Medical records to Primary Physician

DATE: ____________________

I, ____ HEREBY AUTHORIZE **DAVID T NEMOTO M.D., P.A.** TO RELEASE MY MEDICAL RECORDS AND ANY INFORMATION INCLUDING DIAGNOSIS AND TREATMENT IN ITS POSSESSION CONCERNING MY ILLNESS AND/OR TREATMENT.

TO: ____
NAME OF PHYSICIAN OR FACILITY

____
STREET ADDRESS

____
CITY, STATE & ZIP CODE

____
TELEPHONE NUMBER FAX NUMBER

θ LAB REPORTS
θ X-RAY REPORTS
θ PROCEDURES & PATHOLOGY REPORTS
θ ALL RECORDS

THE REASON I AM REQUESTING THIS IS BECAUSE:________________________________

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PATIENT SIGNATURE

____
WITNESS SIGNATURE

____
PATIENT NAME

____
WITNESS NAME

____
DATE OF BIRTH

____
S.S. #