

DOUGLAS C. MCCORKLE, M.D., PA
Medical Records Release

ALL ITEMS ON THIS AUTHORIZATION MUST BE COMPLETED IN FULL.

PATIENT: _____

DATE OF BIRTH: _____ PHONE: _____

ADDRESS: _____

THE INFORMATION IS TO BE RELEASED TO:

NAME: _____

ADDRESS: _____

PHONE: _____ FAX: _____

THE INFORMATION I WISH TO HAVE RELEASED (include dates of service):

| | |
|----------------------------|----------------------------|
| _____ History and Physical | _____ Reports of Operation |
| _____ Imaging Reports | _____ Laboratory Reports |
| _____ Audiograms | _____ ALL RECORDS |

PATIENT SIGNATURE OR PERSONAL REPRESENTATIVE

DATE

IF SIGNATURE IS OTHER THAN PATIENT, PLEASE EXPLAIN YOUR AUTHORITY TO ACT FOR THIS PATIENT. _____

WITNESS

DATE