# 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 REPRESENATIVE DATE

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

_____ _____
WITNESS DATE