RELEASE OF MEDICAL RECORD

I, _____, authorize Memorial Hermann Surgery Center Richmond to release any and all information to the following:

_____

_____

_____

_____

For Date(s) of Service:_____ to _____

I understand that by signing this release, confidential information may be revealed, such as: alcoholism, drug abuse, HIV status and mental illness. I also understand that this release will be valid for a period of one (1) year, unless otherwise specified.

Patient's Name: _____
(Please print)

Patient DOB: _____

Patient's Signature: _____

Today's Date: _____

Driver's License Number _____State_____
(Copy Attached)