AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I, _____ (print), authorize Jane A. Burnham, M.D., Ph.D, to release my medical records to the individual or organization listed below. These records may include dictation, labs, testing, radiology reports, psychiatric evaluations, information on alcohol or drug abuse and outside records.

Records are to be sent to:

Name_____

Address_____

_____

Without my expressed written revocation, this authorization will automatically expire one year from today's date. A photographic copy of the authorization is as valid as the original. I hereby release Dr. Burnham from all legal responsibility or liability for the release of this information.

_____

Patient/Legal Guardian Signature Date of Birth

_____

Witness

_____

Date