Dr. Schultz, MD - President

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Authorization for Medical Record Release

Location to request from: _____

Street/address: _____

Main phone: _____

Dates of care: _____

I, _____, *authorized person,

to the patient, _____, Date of Birth: _____,

Give permission to share the medical records requested with Dr. Daniel Schultz, MD and his associates, at Final Diagnosis, Inc. for continuity of care.

_____ _____

*Authorized next of kin/ healthcare surrogate, power of attorney Date

Please forward the following records: (if longer than 50 pages, send in smaller batches)