



3359 Middle Rd., Ste. 1 • Bettendorf, IA 52722

RECORD RELEASE AUTHORIZATION

PATIENT NAME: _____

ADDRESS: _____

DATE OF BIRTH: _____

SOCIAL SECURITY # _____

I _____, hereby authorize the release of my medical records___ x-rays___ to the following office:

OFFICE NAME: _____

ADDRESS: _____

PHONE # _____

FAX # _____

DATE: _____

PATIENT SIGNATURE: _____

DOCTOR SIGNATURE: _____