Medical Authorization

To Whom It May Concern:

Please accept this instrument as full authorization to release any and all information, medical reports, and records desired in connection with the incident for ___________________________, on _____________________________. The reason or purpose for release of information is:
____
____

The person requesting this information and whom the information is to be released is the undersigned, the patient's ____.
(Relationship to Patient)

____
(Signature)

____
(Date)

STATE OF TEXAS
COUNTY OF DALLAS

Before me, a notary public, on this day personally appeared ________________________________, known to me to be the person whose name is subscribed to the foregoing instrument and acknowledged to me that he/she executed the same for the purposes and consideration therein expressed.

Given under the hand and seal of office this _______day of __________________________201__.

____
NOTARY PUBLIC, STATE OF TEXAS

(PERSONALIZED SEAL)
My Commission Expires: ____