Donald Gedarovich, M.D., PC

1426 Main Street, Suite 5
Walpole, MA 02081
Telephone: (508) 660-8874

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I ______________________________ hereby authorize Dr. Donald Gedarovich, M.D. to furnish a copy of my medical records:

Date of Birth: ______________________

__________ All Medical Records or ____________________ Other (specify)
____
____
____

To: ____
____
____
____

I hereby release Dr. Donald Gedarovich, M.D. from all legal liability or responsibility that may arise from the act I have authorized above.

Signed: __________________________ Date: ______________________
____
____
(address)

Designate Relationship to Patient: ___________________________

Witness: ____________________________ Date: ____________ ID Checked: ______

This authorization is valid for one year.

DATE SENT ______________

INITIALS ________________