188 Hospital Drive, Suite 304

Fairhope, AL 36532

Phone (251) 990-1950 Fax (251) 990-1951

Release for Records

Date: _____

Patient's Name: _____ D.O.B _____

Address: _____ Phone number_____

I authorize Dr. Shoemaker, or designated representative, to release information to:

Name or receiving person, agency, or institution: _____

Address: _____

Phone number: _____ Fax number: _____

The following information (please circle)

All Records	Discharge Summary	History and Physical
Lab Reports	Radiology Reports	Operative Notes
Pathology	Other (specify) _____	

_____ _____

Signature of Patient or Guardian Date

_____ _____

Witness Date