PATIENT WAIVER

I, _____(patient, or guardian, or trustee, or conservator, etc.), do hereby authorize the release of any and all medical documents of whatever nature and form of any and all health care providers, including:

_____
(name(s) of care provider(s) for the aforementioned individual). The social security number of the patient is _____, and the date of birth of the patient is _____ . Please disclose to

_____
(name(s) of individual(s) to whom medical records are to be disclosed) all medical records of every nature and form pursuant to this request, with the following exceptions:

_____
(list of medical records that are not to be disclosed). It is understood that any documents disclosed may be used for any and all purposes. This request hereby includes any information that may be protected by any federal or state laws, unless specifically noted in the foregoing.

Dated this_____ day of _____(month/year), at _____(city, state).

_____
(Signature)

_____
(Witness)