

AUTHORIZATION TO RELEASE  
MEDICAL AND HOSPITAL RECORDS

Date: \_\_\_\_\_

TO ALL HOSPITALS, CLINICS, AND  
DOCTORS AS MAY BE CONCERNED:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Date of Birth: \_\_\_\_\_

Social Security #: \_\_\_\_\_

Ladies and Gentleman:

This is your authorization and instruction to furnish SALTWATER INC. and/or its representatives at its expense, copies or any information or medical records in your possession or control which it may require in connection with illness and/or injuries for which I am now under treatment or have been treated in the past.

Photostatic and facsimile copies of this authorization will be considered as valid as the original.

Your cooperation is appreciated.

Sincerely,

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