I,\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ hereby authorize Bradley Axline to release any and all medical records and information pertaining to any medical history to:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Facility/Doctor) (Phone/Fax)

Please check which records are needed:

\_\_\_ Discharge Summary \_\_\_ Laboratory Test

\_\_\_ History & Physical \_\_\_ Radiology Reports

\_\_\_ Progress Notes \_\_\_ Pathology Reports

\_\_\_ OP Report \_\_\_ Other Medical Records \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ Emergency Records \_\_\_ All Records

I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon authorization. Information used or disclosed pursuant to this authorization may subject to re-disclosure and no longer protected. I understand that treatment or payment cannot be conditioned on my signing this authorization except in certain circumstances such as for participation in research programs or authorization of the release of testing for pre-employment purposes.

Signature of Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_