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MITCHELL K. RAUCH, M.D.

AUTHORIZATION TO RELEASE/OBTAIN CONFIDENTIAL INFORMATION

DR.:____

I hereby authorize you to release copies of my medical records to:

Patient's name: ____

and/or Drs. Name: Mitchell K.Rauch,M.D.

____

This covers my medical treatment dated: _MOST RECENT CBC/CMP/Thyroid Profile/TSH/Lipid Profile____________________________________

It is understood that the information so divulged will be treated confidentially.

Patient's signature: ____

Date: ____

Date of Birth: ____________________ Soc. Sec.No:___________________________

Witness: ______________________________ Acct. Number: __________________

AUTHORIZATION MUST BE SIGNED BY THE PATIENT OR BY THE NEAREST RELATIVE IN THE CASE OF A MINOR OR WHEN THE PATIENT IS PHYSICALLY OR MENTALLY INCOMPETENT.