RECORDS RELEASE AUTHORIZATION

TO MARK D. SAUNDERS, M.D.

Doctor or Hospital

3950 SHORE ROAD, WILLIAMSBURG, MI 49690

Address

I hearby authorize and request you to release to:

The complete medical records in your possession concerning my illness and/or treatment during the period from _____ to _____.

Name_____ Date_____

Address_____

Signature_____ Witness_____

(if relative, state relationship)