Authorization for Release of Medical Records

REQUESTOR REQUIRED DOCUMENTATION:

- **Spouse/Next of Kin** – Healthcare Power of Attorney, Court-issued Letter of Administration, or This Form Notarized
- **Parent of Minor Child** – Photo ID or This Form Notarized
- **Guardian** – Court-issued Guardianship Papers or This Form Notarized
- **Executor/Administrator/Attorney in Fact** – Court-issued Letters of Administration, or This Form Notarized
- **Patient's Healthcare Power of Attorney** – Copy of Healthcare Power of Attorney or This Form Notarized

STATE OF: _____

COUNTY OF: _____

I, _____, Notary Public for said county and state, do hereby certify that,

_____personally appeared before me and acknowledged that he/she is the

(You MUST indicate which applies) **–**

1. Spouse/Next of Kin
2. Parent of Minor Child
3. Guardian
4. Executor/Administrator/Attorney in Fact
5. Healthcare Power of Attorney

for _____, (patient).

Witness my hand and seal this _____day of _____, 20_____.

_____

Notary Public

(SEAL)

My Commission Expires: _____