**AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION**

I hereby give permission to:

To release to: [Lawyer Name]

Records of all my hospitalization and/or treatments/investigations

Records of my in-patient hospitalizations for the period of:

 to

Month, Year Month, Year

Records of my in-patient hospitalizations and/or treatments/investigations done as an out- patient for the period of:

 to

Month, Year Month, Year

Specify any exclusion to the above:

# Full Name of Patient:

**Date of Birth:**

# Phone Numbers:

**Address:**

# Signatures: x

Witness

**Date:**

dd/mm/yyyy