



## HIGH LINE REHAB

Records Release Authorization Request Form  
( print and sign name only)

To: \_\_\_\_\_  
Doctor, Hospital or Facility

\_\_\_\_\_  
Address

\_\_\_\_\_  
Phone/ Fax #

I hereby authorize and request you to release my complete records in your possession, concerning my illness and /or treatment to

Patient's Name: \_\_\_\_\_  
(Please Print)

Date of Birth: \_\_\_\_\_

Patient's Signature: X \_\_\_\_\_