AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Attn: ____

____

____

Patient: ____

DOB: ________________________

You are authorized to immediately release any and all medical records related to my medical condition and treatment that I may have had during the following time period listed below:

From: ____________________ To: ____________________

To the following person(s), company, or government institution:

Dr. Brian L. Townsend
4917 Richmond-Tappahannock Highway
Aylett, Va 23009
Phone: 804-769-4362
Fax: 804-769-4363

Signed: ____