



HORIZONS DIAGNOSTICS, LLC
Medical Records Release Authorization

I, (Patient Name) _____,
(DOB) _____, (SSN) _____, hereby
authorize Horizons Diagnostics, LLC to release the complete
history and record concerning my illness and/or treatment during
the period of (begin date) _____ (end date) _____.

I so authorize these records to be sent to:

Doctor or Hospital: _____

Address: _____

Phone: _____ Fax: _____

Patient (Guardian) Signature: _____ Date: _____

Witness: _____

Date: _____