Patient Name: ____

Patient Address: ____
Street City State Zip

Date of Birth: ___________

I hereby authorize **DR. HARDIN** to RELEASE information to:

____
Name of doctor, hospital or dentist RECEIVING information

Please mail/fax/email information to:

____
Street City State Zip

(____) __________- ___________
Fax number

____
Email Address

Please send the following information: _________________________________

Covering period of care from _________________ to _________________

I understand that I may revoke this consent at any time except to the extent that action has already been taken on it and it will expire within 90 days from the date below.

By releasing authorized information, Dr. Hardin is hereby relieved from all legal responsibility or liability for the release of the information described above to the extent indicated and authorized herein.

____
Date

____
Signature of Parent

____
Name of Parent

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