PETE GARCIA, M.D.
BOARD CERTIFIED
GENERAL, VASCULAR, AND LAPAROSCOPIC SURGERY

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I _____ this _____
(NAME) (DATE)

do hereby authorize _____
(DOCTOR)

to release my medical information to Dr. Pete Garcia, and any information required regarding my case history, operative notes, office follow-up notes, x-ray films/reports, lab reports, and/or any information pertinent to the disposition of my case.

_____
SIGNATURE OF PATIENT

_____
WITNESS