

PATIENT AUTHORIZATION TO RELEASE INFORMATION

I HEREBY AUTHORIZE MY Attending Physician and/or hospital to release any information, or copies thereof, acquired in the course of my examination or treatment to my employer and/or his representative.

Patient's Name _____

Patient's Signature _____

Date _____

**FORWARD COPY WITHIN 24 HOURS OF INCIDENT TO MANCON® CORPORATE OFFICE
HUMAN RESOURCES – FAX 757-457-9345 or EMAIL HR@MANCONINC.COM**