Paul Rottler, MD., FACS
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Authorization to Release Medical Records

Name of Patient: ___________________________________ Previous Name: ______________

Date of Birth: ___________________

I, the undersigned, authorize the release of, or request access to the information specified below from the medical record(s) of the above name patient.

Information to be released:

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I hereby give consent for the above information to be released to:

Paul Rottler, MD phone (314) 966-8880, fax (314) 966-5811_____________________________

From: ____

____

Patient Signature: _________________________________ Date: ________________________

Please forward the available information as soon as possible for further medical treatment.

Thank You