PAUL ROTTLER
MD, FACS.

Authorization to Release Medical Records

Patient Name: _____ **Previous Name:** _____

Date of Birth: _____

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

Information to be released: _____

I hereby give consent for the above information to be released to Dr. Paul Rottler. Information can be faxed to (314) 966-5811 or emailed to info@dr-rottler.com.

Information to be released from: _____

_____

Patient Signature: _____ **Date:** _____

13625 Big Bend Road St. Louis, MO 63122
Phone (314) 966-8880
Fax (314) 966-5811
Email info@dr-rottler.com