AUTHORIZATION FOR EXAMINATION
OF PHYSICIAN'S RECORDS

TO DR (s): _____
Or any healthcare facility that may have information concerning my treatment.

PHONE #: _____

FAX #: _____

I authorize you to furnish a copy of the medical records and any testing results with films of the said patient covering the period from: _____ to: _____ or allow those records to be inspected or copied by:

STEVEN K. SEWELL, M.D.
1608 S. 5th Street
Leesville, LA 71446
Phone: 337-392-1000
Fax: 337-392-1099

I release you from all legal responsibility or liability that may arise from this authorization.

Patient: _____ D.O.B. _____

Signed: _____ (Patient/Legal Guardian)

Date: _____