

TO WHOM IT MAY CONCERN: I, the undersigned, do hereby authorize release of my medical records and any other information relative to my treatment of Records to be faxed/mailed to: PATIENT NAME: DATE OF BIRTH: ______ PHONE#_____

Kenneth A. Hacker, MD, FACS • Laurel A. Yeager, MD, FACS • Jennifer L. Etling, MD, FACS • Jerad P. Miller, MD, FACS, FASCRS • Melissa M. Franke, FNP-C

SIGNATURE OF PATIENT (GUARDIAN IF PATIENT IS A MINOR)