

AUTHORIZATION FOR MEDICAL RECORD RELEASE FROM CIVILIAN FACILITIES
NHPAXRIVMD 6320/76

DATE _____

TO: _____

NAVAL MEDICAL CLINIC
MEDICAL RECORDS
47149 BLISS ROAD
PATUXENT RIVER, MD 20670

I HEREBY REQUEST AND AUTHORIZE YOU TO FURNISH TO _____

ALL INFORMATION YOU MAY HAVE CONCERNING MYSELF AND OR MY MINOR CHILDREN WITH THE RESPECT TO MY ILLNESS OR INJURY, MEDICAL HISTORY, CONSULTATION PRESCRIPTIONS AND OR TREATMENT, INCLUDING X-RAYS, AND COPIES OF ALL HOSPITALS OR MEDICAL RECORDS IN YOUR POSSESSION CONCERNING MYSELF AND OR MY MINOR CHILDREN, OR WHATEVER NATURE.

SIGNED: _____

ADDRESS: _____

