



BodyWorks

BodyWorks, Inc.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I, _____ hereby authorize
_____ to release
_____ medical records and information to the following
individual(s) or group of individuals, and/or facility: _____

The information will be used/disclosed for the following purposes: _____

Signature: _____

Date: _____

Relationship to the patient: _____

Witness: _____