ROCKWALL SURGICAL SPECIALISTS

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DAVID RITTER, MD *ASHLEY EGAN, MD* *JON HARRIS, MD* *JOSHUA MARK, MD*

AUTHORIZATION TO RELEASE INFORMATION

I,_____, here by authorize _____

to release the following medical records to:

Rockwall Surgical Specialists
Dr. David Ritter, Dr. Ashley Egan, Dr. Jon Harris, Dr. Joshua Mark
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Please forward: _____ All Medical Records

_____ Lab & Radiology Reports Only

_____ Operative Reports Only

_____ Other: _____

Patient Name:_____ DOB:_____

SSN:_____ Phone Number:_____

Address:_____

Signature of Patient or Guardian:_____

Date:_____