Authorization for release of records to:
Dr. William and Dr. Erin Johnston
Johnston Health Center
(Please fax this form back with the records)

On Behalf of Dr. William Johnston and Dr. Erin Johnston, Johnston Health Center I__________________________________ give permission to receive/send the above listed reports on my behalf. I release from you all legal responsibility or liability that may arise from this authorization.

Signature of Patient:______________________________
Date of Birth:_____________________
(If patient is under age of 18 legal guardian/parent)
Date:________________
Witness:__________________

FOR OFFICE USE ONLY

PLEASE SEND THE FOLLOWING REPORTS WITH THE SIGNED AUTHORIZATION FORM

- ○ Health Records
- ○ X-rays
- ○ Laboratory Results
- ○ Other:____

____

Doctor: (signature)__________________________________ Date: ______________________

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