LAURENCE WEIDER, M.D.
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RELEASE OF RECORDS

I, _____, give authorization for the following person(s) to receive and information pertaining to my medical treatment and care from the office of Laurence Weider, M.D. I understand that the office of Laurence Weider, M.D. cannot release information to anyone that I have not provided below.

Person(s) I give authorization to:

1. _____ Relationship _____

2. _____ Relationship _____

3. _____ Relationship _____

4. _____ Relationship _____

_____
PRINTED NAME OF PATIENT

_____
SIGNATURE OF PATIENT OR RESPONSIBLE PARTY DATE