

**RELEASE OF INFORMATION**

Patient Name: \_\_\_\_\_  
First Middle Initial Last

DOB: \_\_\_\_\_

The undersigned hereby authorizes and requests Byron T. Westerfield, M.D. to provide records to:

\_\_\_\_\_  
Name

\_\_\_\_\_  
Address

Fax Number: \_\_\_\_\_

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Signature