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CAYUGA MEDICAL CENTER
AT ITHACA
101 Dates Drive, Ithaca, NY 14850

AUTHORIZATION FOR RELEASE OF INFORMATION

Date: Jan 17, 97

I hereby authorize Cayuga Medical Center at Ithaca to release copies of my medical records to:

_____

_____

_____
(authorized designee)

REASON FOR REQUEST: going to the Doctors

DESCRIPTION OF INFORMATION TO BE RELEASED:

Patient Name: Saunders Kevin

M.R. NO.: _____ D.O.B.: _____

Other Names: _____

Dates of Hospitalization or Treatment: _____

_____

_____

I also, release Cayuga Medical Center at Ithaca from all legal liability that may arise from release of information requested.

X _____
(signature of patient or next of kin)

_____
(relationship, if other than patient)

Janice Jones
(prepared by)

✓ DONE _____ NOT DONE

5/93 revised
9/95 revised