AUTHORIZATION TO RELEASE
MEDICAL AND HOSPITAL RECORDS

Date:_____

TO ALL HOSPITALS, CLINICS, AND
DOCTORS AS MAY BE CONCERNED:

Name: _____

Address:_____

_____

_____

Date of Birth: _____

Social Security #:_____

Ladies and Gentleman:

This is your authorization and instruction to furnish SALTWATER INC. and/or its representatives at its expense, copies or any information or medical records in your possession or control which it may require in connection with illness and/or injuries for which I am now under treatment or have been treated in the past.

Photostatic and facsimile copies of this authorization will be considered as valid as the original.

Your cooperation is appreciated.

Sincerely,

_____