

**AUTHORIZATION FOR RELEASE
OF MEDICAL INFORMATION**

I hereby authorize _____

To release medical information including diagnosis, medical care, treatment, laboratory results, pathology reports and/or slides, and all tests performed, or specifically as follows _____
_____ regarding:

Name _____ D.O.B. _____

To:

James A. Zalla, M.D.
7766 Ewing Blvd, Suite 100
Florence, KY 41042

Mae L. Dinn, PA-C
7766 Ewing Blvd, Suite 100
Florence, KY 41042

Mark J. Zalla, M.D.
7766 Ewing Blvd, Suite 100
Florence, KY 41042

Kristin D. Kennedy, APRN
7766 Ewing Blvd, Suite 100
Florence, KY 41042

Susan J. Bushelman, M.D.
7766 Ewing Blvd, Suite 100
Florence, KY 41042

Marie N. Sartori, APRN
7766 Ewing Blvd, Suite 100
Florence, KY 41042

Molly G. Eisner, M.D.
7766 Ewing Blvd, Suite 100
Florence, KY 41042

Witness Signature

Signature of Patient

Date