



National Institutes of Health
Bethesda, Maryland 20892

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

TO: _____

I hereby request and authorize you to release medical information concerning me, with particular reference to:

Please release and send information to:

Medical Officer in Charge
Occupational Medical Service
Attention: _____
National Institutes of Health
Building 10, Room 6C-306
Bethesda, MD 20892

Signed: _____
Address: _____

Witnessed: _____ Date: _____

Please print patient name and identification number:
