



Dr. Giuseppe Corinella
Dr. Michael E. Davis

AUTHORIZATION FOR MEDICAL INFORMATION

To Whom It May Concern:

I hereby authorize all physicians, hospital and medical attendants to furnish full and complete medical records, reports and treatment concerning me to Dr. Corinella and/or Dr. Davis.

Patient's Signature

Date

Patient - Please print name

Witness

I hereby give Dr. Corinella and/or Dr. Davis permission to release my medical records when requested

Patient's Signature

Date

Witness