

AUTHORIZATION TO RELEASE MEDICAL RECORDS

DATE: _____

I hereby authorize: _____

to release my medical records (including xray films
and reports) to:

CHARLES E. WILHITE, M.D., INC.

NICHOLAS KOMAS, M.D., INC.

111 Raley Boulevard, Suite 160

Chico, CA 95928

Telephone: (530) 891-6375

Fax: (530) 891-6952

NAME: _____

SIGN: _____

D.O.B.: _____