City of Center

Police Department

Medical Records Release Authorization

Date: _____

ATTENTION: Physicians, Nurses, Hospitals and Medical Facilities at which I have received medical care provision By this authorization or a copy hereof, I_____ DOB_____ authorize you to release, to any Officer of the Center Police Department, any law enforcement officer and the office of the Ralls County Prosecutor for inspection, recording, copying, all medical records, reports, statements, in reference to any medical treatment and hospitalization as a result of an incident occurring on:
Date _____Time _____
At location: _____.
This written permission is being given voluntarily and without threats or promises of any kind.

Witness _____ Signed _____

Witness _____ Date _____ Time _____

103 S. Public • P.O. Box 241 • Center, MO 63436
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