STATE OF WEST VIRGINIA
BOARD OF OSTEOPATHIC MEDICINE
405 Capitol Street, Suite 402
Charleston, WV 25301

Phone: 304-558-6095
Fax: 304-558-6096

RECORDS RELEASE AUTHORIZATION

I hereby authorize and request you to release my records to:

WEST VIRGINIA BOARD OF OSTEOPATHIC MEDICINE
405 Capitol Street – Suite 402
Charleston, WV 25301

The complete history records in your possession, concerning my illness and/or treatment during the period from _____ to _____.

Name: _____ Date: _____

Birthdate: _____

Address: _____

_____

Signature: _____

******NOTARIZATION REQUIRED ******

Witness: _____

To: _____
(Doctor or Hospital)

Address: _____

_____

Subscribed and sworn to before me this _____ day of _____, 20____, in the

County of _____, in the State of _____.

My commission expires: _____. (SEAL)

Signature: _____