JEFFREY D. HARRIS, M.D.
Caduceus Corporation
6400 Clayton Road, Suite 316
St. Louis, MO 63117
314-647-7801

AUTHORIZATION TO OBTAIN OR RELEASE INFORMATION

I authorize and request: ____

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To release to: JEFFREY D. HARRIS, M.D.

Purpose of release: ____

Types of records requested: ____

Identifying Information:

Patient's Name: ______________________________ SS#: ______________

Date of Birth: ______________________ Maiden Name: ________________

Authorization Expires: ____
If not otherwise specified, this consent shall expire 90 days after it is signed.

______________ Date

______________________ Patient's Signature