AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____ do hereby authorize the release of my medical records
print full name/date of birth

from _____ _____ _____(practitioner's name and address) to:

The Virgin Islands Board of Medical Examiners
PO Box 222995
Christiansted, VI 00822-2995

_____ _____
Signature Date

_____
Print Name

Subscribed and sworn to before me this ____day of _____ 20____

_____
Notary Public

_____
My Commission Expires