



**City of Philadelphia  
POLICE ADVISORY COMMISSION**

**P.O. Box 147  
Philadelphia, PA 19105-0147  
215-686-3991**

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**To Whom It May Concern:**

**In connection with an official investigation being conducted at my request, I hereby authorize the release to the Police Advisory Commission of all medical information and reports relating to my treatment at your facility on the below date(s):**

**Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_  
\_\_\_\_\_

**Date of Birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Social Security No:** \_\_\_\_-\_\_\_\_-\_\_\_\_  
\_\_\_\_\_

**Date/Time of Hospitalization:** \_\_\_\_/\_\_\_\_/\_\_\_\_ \_\_\_\_:\_\_\_\_ AM/PM

**Signature of Patient or Legal Guardian:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**File No:** \_\_\_\_\_