## **ROCKWALL SURGICAL SPECIALISTS**

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## **AUTHORIZATION TO RELEASE RECORDS**

l,	, here by authorize Rockwall Surgical Specialist	s to release the
following records to:		
Release To:		
Phone:		
Address:		
Please release the following records:		
All My Records Operative Report / Path Radiology Results / Lab Other:	Results	
Patient Name:		
Patient's Phone Number:		-
Patient's Address:		_
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