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AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient's Name: _____ Date of Birth:_____
(Please Print)

I hereby authorize and request that the following medical records:

_____ All Medical Records

_____ Records Dating _____ to _____

_____ Other

_____

To Be Released To:

Name: _____ Phone: _____

Address: _____ Fax: _____

_____

_____ _____
Signature of Patient or Parent/Guardian Date