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MEDICAL RELEASE

This is to authorize the release of my medical records to the following physician/facility:

DATE: _____

NAME OF
DOCTOR/FACILITY:_____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

TELE: _____ FAX: _____

PATIENT NAME: _____

DATE OF BIRTH: _____ SS#: _____

REQUESTED RECORDS: _____

_____

_____

PATIENT SIGNATURE: _____ TELE: _____