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RELEASE OF MEDICAL RECORDS

(PLEASE PRINT)

_____

Patient's Name Date of Birth Phone

_____

Address City State Zip Code

I HEREBY AUTHORIZE

Doctor _____ Phone _____

_____

Address City State Zip Code

TO RELEASE MY RECORDS TO

_____

Doctor/Other Phone Fax

_____

Address City State Zip Code

- ❑ ALL RECORDS
- ❑ ALLERGY
- ❑ OTHER _____

SIGNATURE: _____ **DATE:** _____

RELATIONSHIP: _____