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PATIENT AUTHORIZTION TO RELEASE MEDICAL RECORDS

PATIENT INFORMATION

NAME: _____

DOB: _____ SS#: _____

ADDRESS: _____

_____

I hereby authorize and request that you release my complete history and medical records in your possession concerning my illness and/or treatment.

I hereby authorize release of my medical records to:

Release records to:

NAME: _____

ADDRESS: _____

_____

PHONE: _____ FAX: _____

_____ _____

PATIENT SIGNITURE DATE