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RELEASE OF MEDICAL RECORDS

Please release a copy of:

( ) All medical records

( ) All medical test/lab results

( ) Medical records from dates__________ to __________

( ) Other____

The undersigned patient,____________________________________, requests the release of his/her records/results to:

Name:___________________________________

Address:_________________________________

____

Phone:___________________________________

Fax:_____________________________________

Thank you for your immediate attention.

_______________________________ Name of Patient/Guardian (PRINT)

_______________________________ Signature of Patient/Guardian

_______________________________ Date

_______________________________ Witness Signature