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CONSENT TO RELEASE MEDICAL RECORDS

RELEASE MEDICAL RECORDS FROM:

Doctor or Office: _____

Address: _____

City/State/Zip: _____

SEND MEDICAL RECORDS TO:

Doctor or Office: _____

Address: _____

City/State/Zip: _____

Phone/Fax: _____

All records unless specified: _____

Patient Name: _____ Date of Birth: _____

Signature: _____ Date: _____

There may be a charge incurred for obtaining records