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REQUEST FOR RELEASE OF MEDICAL RECORDS

Date Requested:_____ Date Sent:_____

To:_____Fax #_____
(Physician's Name)

(Address) (City) (State) (Zip Code)

I hereby request that my medical records be released to:

(Physician's Name)

(Address) (City) (State) (Zip Code)

(Patient's Name)

(Patient's Signature)

(Address) (City) (State) (Zip Code)

(Birthdate) (Social Security Number)