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MEDICAL RECORDS RELEASE

Date: _____

TO WHOM IT MAY CONCERN:

I authorize the release of all necessary medical records to:

NAME: _____

ADDRESS: _____

CITY: _____

STATE, ZIP: _____

PHONE #: _____

FAX # : _____

Signature: _____
(If relative, state relationship)

Print Name: _____

Date of Birth: _____

Doctor: _____
(In this office)