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Release of Records

Patient Name: _____

Patient Address: _____

DOB: _____

Date: _____ Phone: _____

Facility/Doctor Name: _____

Address: _____

City:_____ State: _____ Zip: _____

Phone: _____ Fax: _____

Dates of service: _____ to _____ (this must be completed)

- Complete Medical Record
- Labs
- Xray/MRI/CT

I authorize the release of my medical records.

Patient Signature:_____ Date: _____