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REQUEST FOR RELEASE OF MEDICAL RECORDS

Date Requested:________________Date Sent:________________________

TO:____
(Physicians Name)

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

I hereby request that my medical records be released to:

____
(Physician Name)

____
(Physician Address) (City) (State) (Zip Code)

____
(Patient's Name)

____
(Patient's Signature)

____
(Patient Address) (City) (State) (Zip Code)

____
(Birth date) (Social Security Number)

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