MEDICAL RECORD RELEASE

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PATIENT INFORMATION:

NAME: _____

DATE OF BIRTH:

_____

ADDRESS: _____

TELEPHONE#: _____ **FAX#** _____

SIGNATURE: _____

DATE : _____

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I HEREBY REQUEST THAT MY MEDICAL RECORDS BE RELEASE TO:

DOCTOR:_____

ADDRESS : _____

PHONE: _____

FAX: _____