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**RELEASE OF MEDICAL RECORDS  
(PLEASE PRINT)**

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Patient's Name	Date of Birth	Phone
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Address	City	State	Zip Code
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**I HEREBY AUTHORIZE**

Doctor	Phone
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Address	City	State	Zip Code
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**TO RELEASE MY RECORDS TO**

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Doctor/Other	Phone	Fax
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Address	City	State	Zip Code
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- ALL RECORDS
- ALLERGY
- OTHER \_\_\_\_\_

**SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**RELATIONSHIP:** \_\_\_\_\_