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MEDICAL RELEASE

TO: _____
Name of Facility/Doctor Where Records are Located

_____
Address

_____
City State Zip

From: _____
Patient's Current Name/Previous Name as Known by Facility

_____
Address

_____
City State Zip

DOB: _____ SS# _____

PH# _____

PLEASE RELEASE MY MEDICAL RECORDS TO:

DR. _____

Address: _____

City/State/Zip _____

Phone# _____ FAX# _____

SIGNATURE: _____ DATE _____