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Authorization to Release Medical Records

I authorize Dr. /Clinic: _____

Fax number: _____ Phone Number: _____

To disclose information to Dr. /Clinic: _____

Fax : _____ Phone Number: _____

Documents including: _____

Patient's Name: _____
(Print name please)

Date of Birth: _____

Signature of Patient or Guardian:

Date:

Comments: _____

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