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RECORDS RELEASE AUTHORIZATION

To: _____
Doctor or Hospital

_____
Address, Phone #, Fax#

I hereby authorize and request you to release to: _____

_____

_____

The complete history records in your possession, concerning my illness and/or treatment during the period from _____ to _____.

Name: _____ DOB: _____

Address: _____

Phone #: _____

Signature: _____ Date: _____
(If representative, state relationship)

Witness: _____ Date: _____