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RECORDS RELEASE AUTHORIZATION

DATE:_____

I AM REQUESTING RECORDS FROM:

_____
DOCTOR OR HOSPITAL

ADDRESS_____

CITY_____STATE_____ZIP_____

I HEREBY AUTHORIZE AND REQUEST YOU TO RELEASE THE COMPLETE HISTORY RECORDS IN YOUR POSSESSION CONCERNING MY MEDICAL CARE TO:

_____
DOCTOR

ADDRESS_____

CITY_____STATE_____ZIP_____

_____
PATIENT'S FULL NAME (PLEASE PRINT)

_____
DATE OF BIRTH S.S.#