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MEDICAL RECORDS RELEASE

Date: _____

Patient Name: _____

DOB: _____

SS #: _____

To _____

_____

I Hereby Authorize You To Release To

_____

_____

- ÿ **Any Information including The Diagnosis And Records Of My Treatment Or Examination Rendered To Me During The Period**
- ÿ **Others specific records: _____**

From: _____ To: _____

Signature _____

Name_____

(please print)

Witness _____