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### MEDICAL RECORDS RELEASE

DATE: \_\_\_\_\_  
PATIENT: \_\_\_\_\_  
DOB: \_\_\_\_\_  
SSN: \_\_\_\_\_

I hereby request that all medical records be released to:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signature of Patient/Parent or Guardian

\_\_\_\_\_  
Signature of Witness