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RELEASE OF MEDICAL INFORMATION

DATE_____

To:_____

Phone:_____
Fax:_____

You are hereby authorized and requested to furnish to:_____

_____

any and all Medical Information, history, records, diagnosis, reports, or x-rays in your possession concerning the undersigned

_____ _____
Patient Signature **Date of Birth**

_____ _____
PATIENT (PRINT) Approved: Attending Doctor

_____
Signature of Parent or Guardian

PLEASE FAX OVER ANY REPORTS ASAP