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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****

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