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Records Release

Doctor or Hospital _____

Address _____

Phone(_____) _____ **Fax**(_____) _____

I HEREBY AUTHORIZE AND REQUEST YOU TO RELEASE MY RECORDS TO:

Doctor or Hospital _____

Address _____

Phone(_____) _____ **Fax**(_____) _____

**THE COMPLETE MEDICAL RECORDS IN YOUR POSSESSION, CONCERNING MY
ILLNESS AND/OR TREATMENT DURING THE PERIOD:**

FROM _____ **TO** _____

Name/DOB _____

Signature _____

Date _____ **Witness** _____