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 3581 Old Washington Rd
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Medical Records Release Request

Regarding

Patient Last Name: _____ Patient First Name: _____

Patient Date of Birth: _____

Records Requested FROM

Physician or Institution's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

I Hereby Request My Medical Records Be Released and Submitted TO

Physician or Institution's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Specific Request: _____

Reason for Request: _____

 Patient Signature

 Date Signed

 Witness Signature

 Date Signed