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Medical Records Release

Patient Name Address	Birth date SS # Phone
	to release my medical records Phone Fax
I authorize the release of the following All Records Surgery/Procedure Notes History and Physical Lab Results	: (Please check all that apply) All records between dates// to// Test results Visit notes Other:
Please read carefully. I do not authorize the release o Confidential information related diagnosis and treatment.	the following information: to HIV, communicable disease, alcohol or drug use, and mental health
Please release my records to: Address	Phone Fax
Reason for Request:	
 Treatment will not be condition purpose of creating protected h 	
Signature of patient or authorized guardian	Date
Witness Signature	Date