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PATIENT RECORDS RELEASE

Date: _____

TO: (facility where records are held)

Name: _____

Address: _____

I hereby authorize you to release to:

Medical records including the diagnosis and records of any treatment or examination rendered to me during the period from _____ to _____, or all records on file _____.

Signature

Date

Address

Social Security Number

Date of Birth

Witness

Chart #

FAX TO: 865 971 4887