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AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize
Hospital/Doctor: _____ Phone: _____

Patient Name: _____

Date of Birth: ___/___/___

Social Security Number: _____/_____/_____

You are hereby authorized to release copies of my medical record to the above named person/facility at my request.

___ ALL RECORDS

___ HISTORY & PHYSICAL

___ LAB REPORTS, XRAY'S, MRI'S, CT SCANS, PATHOLOGY REPORTS

___ OPERATIVE REPORTS

Patient Signature

Parent/Guardian Signature