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AUTHORIZATION TO RELEASE MEDICAL RECORDS

Date: _____

Full Name of Patient/s:

Name of Person Requesting Records:

Relationship to Patient/s:

Reason For Request:

Standard Transfer Packet

OR

Specific Records Requested:

Name and Address of person to forward medical records to:

I attest that I have a legal right to these medical records as either the patient or the legal guardian/parent.

SIGNATURE _____

FEE _____

PAID

AT DESK FOR PICKUP

MAILED