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RECORDS RELEASE AUTHORIZATION

TO: _____
DOCTOR/HOSPITAL/MEDICAL FACILITY

_____
ADDRESS

I hereby authorize and request you to release the complete history records in your possession concerning my illness and/or treatment during the period from _____to _____.

Name:_____Date of Birth:_____

Address:_____
_____
_____

Signature:_____Witness:_____

Date Signed:_____