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PATIENT MEDICAL RECORDS REQUEST FORM

(Please Print)

Date: _____

Patient Name: _____

Patient Address: _____

DOB: _____

I hereby request a copy of my medical records be RELEASED FROM:

PLEASE FORWARD MEDICAL RECORDS TO:

Patient Signature: _____

Print name: _____

Date: _____

Witness of Patient Signature: _____

Print name: _____

C: Patient file