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REQUEST FOR RELEASE OF MEDICAL RECORDS

I, _____ hereby authorize the
(print name)

release of my medical records from _____ to _____
(date) (date)

To: _____

_____

_____

_____
Signature of Patient DOB Date

FIRST TWO YEARS OF RECORDS WILL BE PROVIDED FREE OF CHARGE
THERE WILL BE A FEE ($15 PREPARATION PLUS 25¢ PER PAGE) FOR RECORDS OVER TWO YEARS. POSTAGE WILL BE CHARGED FOR RECORDS MAILED TO PATIENT.