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Gynecology

MEDICAL RECORDS RELEASE

Patient's Name:_____

Date of Birth:_____

Social Security #:_____-_____-_____

I hereby authorize my medical records to be released to:

Doctor/Patient's Name:_____

Address:_____

City, State, Zip:_____

Phone/Fax:_____

My records should be under the following name:

First Middle Last

_____

Patient's Signature Date