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# Authorization to Release Medical Records

To: ____________________________________________

Re: ____________________________________________

Date: ____________________________________________

I hereby authorize you to forward the following Medical Records:

_____ X-rays and/or X-ray reports

_____ Laboratory Test Results

_____ Examination Findings

_____ Summary of Medical History

_____ Other: ____________________________________________

Thank you for your assistance in providing for this patient's medical care.

Respectfully,

______________________________ DOB: _____________
(Signature of Patient)

______________________________
(Signature of Doctor)