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Authorization to Release Medical Records

I, _____, hereby authorize disclosure of the named individual's health information as described below. My relationship to the patient is _____ and I have the authority to act on their behalf.

Patient Name: _____ DOB: _____

Records requested from: Physician: _____

Address: _____

Phone: _____ Fax: _____

All records requested Records dated _____ thru _____

Signature of Parent or Guardian

Date

Drivers License Number