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MEDICAL RECORDS RELEASE

PATIENT NAME _____

DATE OF BIRTH _____

ADDRESS _____

RECORDS REQUESTED _____

RELEASE RECORDS TO _____

COMMENTS _____

I HEREBY AUTHORIZE THE LAB OF PATH, P.A. TO RELEASE MY MEDICAL RECORDS TO THE ABOVE REQUESTING ENTITY.

SIGNATURE

DATE

Lab of Path use only: Method of Information Released
_____ Fax _____ Mail _____ FedEx _____ Patient