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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

DATE: _____

TO:

I hereby request that my records be forwarded to:

By signing below, I hereby grant my voluntary consent to disclose any portion of my otherwise confidential medical information in any format including, but not limited to laboratory slides related to my medical care to the above named person.

Patient Name: _____ Date of Birth: _____

Signature of Patient or legal guardian: _____

Witness Signature: _____

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