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Consent to release of medical records:

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Date of service: \_\_\_\_\_

Information requested: \_\_\_\_\_

From: \_\_\_\_\_  
\_\_\_\_\_

To: \_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date