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## REQUEST FOR MEDICAL RECORDS RELEASE

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Address, City, State, Zip

Information requested: Medical

\_\_\_\_\_  
Entire Medical Records

\_\_\_\_\_  
History and Physical and Progress Notes

\_\_\_\_\_  
Radiology, Labs, Etc

\_\_\_\_\_  
OP Reports

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

\_\_\_\_\_  
Date