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(831) 648-8020

Request for Medical Records Release

Patient Name: _____

DOB: _____

I, _____, hereby authorize the undersigned physician to release any or all medical information specified below.

_____ **All Records**

_____ **Specified Records**_____

Physician's Name: _____

Release to: _____

Phone number: _____ Fax number: _____

Authorized Signature: _____

Date: _____

Medical Records subject to a $25.oo copying fee.