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**RECORDS RELEASE**

**Patient Name:** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_

*I hereby authorize the release of my records to:*

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Date: \_\_\_\_\_ Patient's Signature: \_\_\_\_\_

(Parent or Legal Guardian must sign for patient if patient is under 18)

Date: \_\_\_\_\_ Witness Signature: \_\_\_\_\_