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MEDICAL RECORD RELEASE REQUEST

Name of Physician: ____

Physician Address: ____
Street

____
City State Zip Code

Approximate Dates Treated: ____

Patient Name: ____
Last First Initial

Previous Name: ____
Last First

Current Address: ____
Street

____
City State Zip Code

Date of Birth: ____
Month/Day/Year

Telephone: Cell: ______________ Home: ______________ Work: ______________

I HEREBY AUTHORIZE THE RELEASE OF A COPY OF MY MEDICAL/GYNECOLOGICAL RECORDS TO JEWEL AMUI-BELLON, M.D.

____ ______________________
Signature of Patient/Guardian Date

____ ______________________
Witness Date