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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Re:__________________________________

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SS#:__________________________________

Authorizing is hereby granted to:

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To release a copy of all medical records and information to:

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Patient's Signature:______________________

Date:__________________________________

The person (s) listed below have permission to speak with representatives of ADA Gd]bY UbX Gdcfhg D\mg]W]Ubg regarding my account, billing and treatment:

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