

MEDICAL RECORDS RELEASE

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I, _____, hereby authorize the release of any and all medical records relating to my care during the period of _____ to _____.

PATIENT'S NAME: _____

DATE OF BIRTH: _____ PHONE:(_____) _____ - _____

ADDRESS: _____

CITY: _____ ST: _____ ZIPCODE: _____

SIGNATURE: _____ TODAYS DATE: _____

PLEASE CHECK ONE OF THE FOLLOWING:

1. PLEASE SEND MY MEDICAL RECORDS TO DR. HARDY FROM:

Dr/Hospital: _____

Address _____

City _____ St _____ Zip _____

Phone(_____) _____ - _____ Fax (_____) _____ - _____

2. PLEASE SEND MY MEDICAL RECORDS FROM DR. HARDY TO:

Dr/Hospital: _____

Address _____

City _____ St _____ Zip _____

Phone (_____) _____ - _____ Fax (_____) _____ - _____

3. PLEASE RELEASE MY MEDICAL RECORDS TO MYSELF (there is a **minimum fee** of **\$25** for medical records).

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