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CONSENT TO RELEASE MEDICAL RECORDS

Records to be sent to the following address:

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Records to be received from:

The release of information regarding psychiatric, drug or alcohol abuse treatment, HIV or AIDS testing, counseling and treatment, sexually transmitted disease diagnosis and treatment and other sensitive medical information may be included in my medical report. By signing below I authorize release of any and all medical information to the above requester.

Signed: _____
(Patient, Parent or Guardian)

Date: _____

Patient Name: _____ D.O.B. _____ SS #: _____