Advanced Internal Medicine, Inc.

Mubarik Khan, M.D.

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RELEASE OF MEDICAL RECORDS

Date:
`o:
Address:
Phone : Fax :
ime span seen:
PATIENT INFORMATION:
Patient:
DOB:
To Whom It May Concern:
This letter is requesting that my medical and/or psychiatric records, specifically: be released and sent to Dr. Mubarik Khan at the above Pender Dr. address/fax number.
Thank you,
Signature Witness
Name :
Address:
Phone: