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Medical Records Request

| | |
|--------------------|--------------------|
| Sending to: | Sending From: |
| Facility location: | Facility Location: |

Fax number or email address of clinic or provider if we are sending records out:

Patient Name(s) & Date of Birth

1. _____
2. _____
3. _____
4. _____
5. _____

I, _____, hereby authorize your facility to release any information including the diagnosis, prognosis, treatment, and any pertinent information related to my child's healthcare for all dates of service with your practice.

Date: _____

Signature: _____

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