Dimensional Health
Innovative Care For You

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AUTHORIZATION FOR RELEASE OF RECORDS

To _____
(*Doctor or Hospital)*

_____
(*Fax Number*)

I hereby authorize and request you to release to **Dimensional Health at 112 E. Queenwood, Morton, IL 61550, Fax: (309)263-1117**_____

_____in your possession concerning

_____, _____
(Patient Name) *(Date of Birth)*

_____
Date

_____
Signature of Patient

_____
Signature of Witness