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MEDICAL RECORDS RELEASE FORM

Doctor's Name: _____

Address: _____

Phone #: _____ Fax #: _____

PLEASE RELEASE ANY PERTINENT MEDICAL RECORDS AND IMMUNIZATIONS FOR

PATIENT'S NAME:	
ADDRESS:	
CITY:	**STATE:**
CELL PHONE #:	**HOUSE PHONE #:**
DATE OF BIRTH:	
PATIENT'S SIGNATURE (if applicable):	
PARENT'S SIGNATURE:	
DOCTOR'S SIGNATURE:	