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Authorization for Medical Records Release

Date: _____

Patient Name: _____

DOB: _____ SS: _____

Address: _____

City/State & Zip Code: _____

Releasing Practice/Physician Name:

Address: _____

City/State & Zip Code _____

I hereby authorize you to transfer the above medical records including all diagnostic procedures, lab work, test results and treatment to C.A.R.E. Pediatrics, LLC.

Signature of Authorizing Person

Date

Relationship to Patient

Witness