COMPLETE WOMEN'S HEALTHCARE
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# MEDICAL RECORDS RELEASE FORM

Patient's Name:_____
Social Security #: _____
Date of Birth: _____

Please release my medical records from the following physician(s):
Name: _____
Address: _____
City, State, Zip:_____
Phone #: _____
Fax #: _____

The release of my records is for continuation of care. This document is to expire six (6) months from date of signature.

_____
Patient's Signature

_____
Date