AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

e undersigned patient or guardian below, hereby authorize the release and furnishing of medic reds regarding the following patient: (Name of patient) (Date of birth) (Recipient of records) ther understand these records may contain information from other health care providers as we mistrative dates which are not strictly medical in nature. I release you from all responsibility that may arise from this authorization.			
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	(Signature of patient or legal guardian)	(Date)	
(Signature of witness) (Date)	(Signature of witness)	(Pata)	