

**ALL WOMEN'S CARE, PLLC
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MEDICAL RECORDS RELEASE

I authorize medical information to be _____ (choose one)

Obtained from _____ Released to _____

Physician or Facility

Address

Phone number

PLEASE RELEASE THE FOLLOWING INFORMATION TO ALL WOMEN'S CARE, PLLC:

Purpose of release: _____

PATIENT'S NAME: _____ DATE OF BIRTH _____

PATIENT'S SIGNATURE: _____

RELATIONSHIP _____

DATE REQUESTED: _____ PLEASE FAX ASAP _____ MAIL: _____

THANK YOU FOR YOUR ATTENTION