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***RECORDS RELEASE AUTHORIZATION***

Date \_\_\_\_\_

To: \_\_\_\_\_  
Name of Hospital or Physician

Address \_\_\_\_\_ Phone \_\_\_\_\_

\_\_\_\_\_ Fax \_\_\_\_\_

I hereby authorize and request you release my medical records in your possession to the Office of John Drulle, MD & Emilia Eiras MD, PC.

Patient name \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_