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### Record Transfer Request

Date: \_\_\_\_\_

To: \_\_\_\_\_

Doctor/ Hospital Name

Address: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_

ZIP: \_\_\_\_\_

I hereby authorize the release of my \_\_\_\_\_  
or copies of such.

Patient Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Patient, Parent or Guardian