

**RECORDS RELEASE**

DATE: \_\_\_\_\_

TO: \_\_\_\_\_

*Doctor or Hospital*

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*Address, City, State, Zip Code*

I HEREBY AUTHORIZE AND REQUEST YOU TO RELEASE



*The Future Of Women's Health*

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THE COMPLETE MEDICAL RECORDS IN YOUR POSSESSION CONCERNING MY  
ILLNESS AND/OR TREATMENT DURING THE PERIOD FROM \_\_\_\_\_ TO

\_\_\_\_\_

SIGNED \_\_\_\_\_  
*(Patient)*

RELATIONSHIP \_\_\_\_\_