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Medical Records Release ($50 charge per set)

Patient name……DOB …….

Patient address……

City, State, ZIP…….

Phone…….

I authorize the transfer of my medical records for continuing care to myself at the above address or:

Practice name……..

Practice address…….

City, State, ZIP……

Phone……

Signed……..Date……

Please return completed form with a check for $50 via mail to:

PO Box 2928
Seal Beach, CA 90740