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Medical Records Release Form

Date:______________________

Patient:____________________

I consent to have all of my medical records, pertaining to my current injury and/or condition, released from Pace + West Physical Therapy and sent to:

Physician/Department: ______________________

Address:________________________

____

____

Phone:________________

Fax: _________________

Patient Name Printed:__________________________ DOB: __________

Patient Signature:____________________________ Date:___________