

**Benjamin Lee, MD**  
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**Medical Records Release Form (Part I)**

I, \_\_\_\_\_ give permission to:

Doctor: \_\_\_\_\_

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

Phone: \_\_\_\_\_

To release all records concerning my care to Dr. Benjamin Lee's Pain Management Office.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Printed Name

\_\_\_\_\_  
D.O.B

\_\_\_\_\_  
SSN#