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Medical Records Release Form (Part II)

I, _____, hereby give my permission for Dr. Lee to release all of my medical records pertaining to my treatment to the following persons or facilities:

Person: _____

Address: _____

Phone: _____

Fax: _____

Person: _____

Address: _____

Phone: _____

Fax: _____

_____
Patient Signature Date

_____
Patient Printed Name

_____
D.O.B

_____
SSN#

_____
Witness