

Blue Ridge Obstetrics and Gynecology

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Records Release

Date of request: _____

My permission is granted to Dr. _____

To disclose to _____

Complete information concerning the medical findings and treatment of

Patient

From _____ to _____
Date Date

I release Dr. _____
From any laws related to disclosure of confidential and privileged information.

Signature _____
Patient or Person Authorized to Consent for patient

Date of Birth _____

Address _____

Witness _____ Date _____