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Date: \_\_\_\_\_

Dear Dr. \_\_\_\_\_

Dr. Phone # \_\_\_\_\_

Dr. Fax # \_\_\_\_\_

This letter will authorize you to provide a copy of the medical records as indicated by the check mark below or to otherwise release confidential information. At this time I am requesting the following:

\_\_\_\_\_ Complete record

\_\_\_\_\_ Records of care from \_\_\_\_\_ to \_\_\_\_\_ only

Please release records for (child's name and date of birth).

\_\_\_\_\_  
\_\_\_\_\_

Signature: \_\_\_\_\_

Date \_\_\_\_\_

The Reasons or purposes for this release of information are:

\_\_\_\_\_  
\_\_\_\_\_

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