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AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

I, _____ hereby authorize Northeast Orthopaedics & Sports Medicine to request copies of my medical records from:

_____ (Physician's Name) _____ (Practice Name)

_____ (Address)

_____ (Phone Number) _____ (Fax Number)

_____ (Patient's Name) _____ (Date of Birth)

_____ (Address) _____ (SS#)

_____ (Approximate Treatment Date[s])

_____ (Patient's Signature) _____ (Date)

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