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Todd Zeh, DC

Authorization to Release Medical Information

To: _____

Please release and forward the following information:

_____ X-Rays _____ MRI/Reports _____ Records

Patient's Name: _____

Patient's Address: _____

Patient DOB: _____

I understand that I have a right to receive a copy of these records, upon my request.

Patient Signature

Date

Signature of Guardian (If patient is under 18)

Date

Comments: _____

