PIEDMONT REPRODUCTIVE ENDOCRINOLOGY GROUP

authorization for release of

MEDICAL RECORDS

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I AUTHORIZE THAT MY MEDICAL RECORDS BE SENT:	TO ☐	FROM ☐	THE BELOW OFFICE

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patient information

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DATE OF BIRTH _____ TELEPHONE _____

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This authorization places no restrictions on any information to be released. If any restrictions are to be placed on information being released, please state:

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SIGNATURE OF PATIENT DATE

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WITNESS DATE

This authorization expires one year from date signed