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Adam T. Crawford, M.D.  
Meredith H. Donnelly, M.D.

## MEDICAL RECORDS RELEASE AUTHORIZATION

I request that my medical records be released FROM:

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Please send them TO:

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Indicate dates of service: From: \_\_\_\_\_ To: \_\_\_\_\_

Indicate reason for records release: \_\_\_\_\_

Check records to be released: History and Physical Records \_\_\_\_\_ Test/X-Rays \_\_\_\_\_

Inpatient Records \_\_\_\_\_ Outpatient Records \_\_\_\_\_ Obstetrical Records \_\_\_\_\_ Other \_\_\_\_\_

Patient's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Patient's Address: \_\_\_\_\_

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Patient's Signature: \_\_\_\_\_

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

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