# MEDICAL RECORDS RELEASE AUTHORIZATION


**DR. DZUNG PHAM**

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TO_____

I here by authorize and request you to release the following records : _____

_____

Any information including the diagnosis and records of any treatment rendered to me during the period from _____

_____ to_____

NAME : _____ DOB : _____

ADDRESS :_____ PHONE : _____

Signature : _____ Date : _____ Witness : _____