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Medical Records Release Form

I,	, as parent or legal
guardian of	, do hereby grant
permission for my child's medical	& immunization records to be released to the
physician indicated below. I unders	stand there may be a charge for copying full medical
records.	
Please send my child's medical reco	ords to:
Patient Name:	DOB:
Parent or Guardian's Name	
Address:	
Signature:	Date: