WINNSBORO MEDICAL CLINIC
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AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORDS

PATIENT INFORMATION

Name: ____

Address: ____

Date of Birth: ____________________ Social Security #: ____________________

I HEREBY REQUEST THAT MY MEDICAL RECORDS BE RELEASED TO:

Name: ____

Address: ____

Purpose for release: ____

____________________ ____________________

Signature of Patient, Legal Guardian, or relative if the patient is unable to sign | Date

____

Witness