Genesis
PLASTIC SURGERY

Records Release

TO _____
Doctor or Hospital

_____
Address

I hereby authorize and request you to release to Dr. Fred Thompson the complete medical records in your possession concerning my illness and/or treatment during the period from _____ to _____.

Specific requests and notes: _____

_____

_____

_____

_____

_____

_____ _____
Printed Patient Name Date of Birth

_____ _____
Patient/Authorized Signature Date

_____
Witness

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