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Release of Records Authorization Form:

Date of request: _____

I _____, request that the office of
Dr. _____ release my medical records to
Dr. Jeffrey Thompsen.

It is with my signature that I authorize your office to forward any documentation
pertaining to my visits.

If you have any questions or concerns regarding the authenticity of this letter please do
not hesitate to contact me.

Signature: _____

Date of Birth _____

Social Security # _____