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**RECORDS TRANSFER REQUEST**

Date: \_\_\_\_\_

I hereby authorize the release of my records to:

To: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Print Patient Name      DOB      Signature of Patient or Guardian