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RELEASE OF RECORDS

Date: _____

I, _____ Date of Birth: _____
(print full name)

Patient Address: _____

(city) (state) (zip code)

AUTHORIZE THE FOLLOWING:

Physician/Hospital _____
Address: _____

(city) (state) (zip code)

Telephone: _____ Fax: _____

TO TRANSFER THE FOLLOWING INFORMATION TO DR. PIOTR LAZOWSKI:

Patient signature: _____ Date: _____

If applicable, legal representative signature: _____ Date: _____

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