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I hereby request a copy of my medical record as detailed below (there is a fee):

❑ Full medical record held by this office.

❑ Medial record for the period _____through_____

❑ A specific portion/section of the record as follows:

_____

_____

_____

Please forward my record to _____ at the following address:

_____

_____

_____

Patient Name: .....

Guardian Name and Relationship to patient:

.....

Signature:

.....

Witness: .....

Date: .....