

San Gabriel Eye Center

San Gabriel Eye Center
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Release of Medical Records Form

This instrument is to request and authorize release of medical records to
San Gabriel Eye Center.

FROM:				Date:
COMPANY:				
ADDRESS:		CITY	STATE	ZIP CODE
PHONE:	Area Code ()			
FAX:	Area Code ()			
Patient Name:			Date of Birth	
Patient Signature				
Patient Address:		City	State	Zip Code
Reason For Transfer:				
Witness Signature:				Date

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