



**DAILEY
PEDIATRICS +**
family medicine

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Authorization to Release Medical Records

Patient's Name

Patient's SS#

Patient's DOB

****Please check below records requested****

☐ **All Medical Records** ☐ **Labs** ☐ **Office Notes** ☐ **Radiology/Imaging**
☐ **Other** _____

You are hereby authorized to release any and all of my medical records to the facility listed above.

Patient Signature

Print Name

Date