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REQUEST FOR MEDICAL RECORDS

Phone:	Fa	эх:	
		ord to be transferred to this I understand that I am liab	
tient Name	DOB	Signature	
	in accurate health summar	ding this practice. Would you, with relevant correspondent and continuity of care.	•
to	_	·	
As we use Best Pr	actice we ask that you plea	ase use .XML format and so e contact us for an alterna	end via email or
As we use Best Pr	actice we ask that you plea	ase use .XML format and se	end via email or