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Medical Records Release Form

By signing this form, I authorize Dr. Pilling's office to release confidential health information about me to the following members of my family or a designated guardian/POA.

Patient Name _____ DOB _____

1. _____ Relationship _____ Phone _____

2. _____ Relationship _____ Phone _____

3. _____ Relationship _____ Phone _____

Patient Signature: _____ Date: _____