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Records Release

Patient Name:_____ Date of Birth:_____
(Print)

I hereby authorize Wolff Orthopedics & Sports Medicine to release any information including the diagnosis and records of any treatment or examination rendered to me during the period

of: _____

to: _____

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address: _____

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phone number: _____ fax number: _____

Signature:_____ Date: _____

Witness: _____