

Trinity Family Medicine

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Authorization of Release of Information

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Patient Last name	First name	MI	DOB
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Address	City	State	Zip
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I authorize release of my medical records (progress notes, labs, x-ray reports, referrals for last 12 months). I understand that my medical record may contain personal or sensitive information. Release of this information is voluntary and protected by law.

Signature

Please send copies of my medical records from:

Physician and/or Clinic Name

Address	City	State	Zip
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Phone #	Fax #
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