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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Date: _____
To: Michael L. Howard, MD, FACS
Robyn R. Leitner, MD, FACS
Mark A. Perlmutter, MD, FACS

I hereby authorize you to release all of my medical records to

Name: _____

Address: _____

Phone #: _____

Signature: _____

(Patient or Legal Guardian)

Print Name: _____

Date of Birth: _____

Address: _____

Phone #: _____

Witness: _____