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MEDICAL RECORDS RELEASE FORM

Release Records From: _____

Release Records To: Association of South Bay Surgeons
23451 Madison Street, Suite 340
Torrance, CA 90505

I hereby authorize and request you to release the complete medical records in your possession concerning my illness and/or treatment during the period from:

DATE: _____ **TO:** _____

Please release all medical records

Special request: _____

Patient's Name: _____

Date of Birth: _____

SS #: _____

Signed: _____ Date: _____

Relationship to Patient: _____

Witness: _____ Date: _____

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