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Specializing in:
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Medical Records Release

I, _____, DOB _____

Authorize Orthopedic Care Physician Network, to release medical information to the following:

Company/Doctor Name/Self: _____

Address: _____

Company/Doctor's Phone # _____

Company/Doctor's Fax # _____

Entire Records _____

Most Recent Visit _____

Disc w/MRI & Xrays _____

Other (Please Specify) _____

Patient's Signature: _____

Patient's Phone #: _____ ***Date:*** _____

A fee may be required for your medical records

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