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RECORDS RELEASE AUTHORIZATION

I, _____ authorize Utah Cardiology to send my complete medical record in your possession, concerning my illness, and/or treatment during the period from _____ to _____.

Name: _____ Date: _____

Address: _____

Signature: _____ Relationship (If not patient): _____

Birth Date: _____ Phone Number: _____

SSN: _____

Please send medical records to: _____

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