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Permission to review records for an Adult

Date: _____/_____/_____

RE:_____
(type of record/imaging study)

I, _____ ,grant permission to obtain, secure, and
(name)

review my health/medical records including testing, x-rays, and other imaging studies.

Signed by:_____ Date._____/_____/_____.

Identifying record information:

Print Name: _____

Sign Name: _____

Date of Birth: _____

Medical Record No. (if known): _____

Note: