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REQUEST FOR RELEASE OF MEDICAL RECORDS

To: _____
Doctor's Name/Person Requesting Records

Address City State Zip

I request that the following medical records be released to:

Stone Run Family Medicine
101 Colonial Way, Suite A
Rising Sun, MD 21911

Patient's Name Social Security # _____ Date of Birth ____/____/____

Patient's Name Social Security # _____ Date of Birth ____/____/____

Patient's Name Social Security # _____ Date of Birth ____/____/____

Patient/Guardian Signature Daytime Phone # _____

Date Signed