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MEDICAL RECORDS RELEASE AUTHORIZATION

TO: _____
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PLEASE FAX/Mail/Email COMPLETE COPIES OF MY MEDICAL RECORDS TO:

Raymond Psonak D.O.

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New Gloucester, Maine 04260

FAX: 757-315-8052

Email: records@ChelationMC.com

SIGNATURE AUTHORIZING RELEASE (Patient/Parent/Guardian)

Today's DATE

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PATIENT'S DATE OF BIRTH

This form should be mailed or sent by Fax immediately to your Doctor(s).