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Medical Records Release

By signing below, I,	, \square give \square deny
permission to The Emergency Center to release by medical records to the	following person:
Person Name:	
Relationship to Patient:	
Phone #:	
The release of my records may include	
 Nursing documentation ER Physician documentation Laboratory reports Radiological reports Discharge summary Billing information Claims status 	
Patient Signature:	Date:
Patient Date of Birth:	