



# Gastroenterology Consultants, P.C.

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## RELEASE OF INFORMATION

PATIENT NAME \_\_\_\_\_

DOB \_\_\_\_\_ SSN/ID# \_\_\_\_\_

TO: \_\_\_\_\_

NAME

ADDRESS

CITY, STATE, ZIP

FAX #

**PLEASE RELEASE ALL PERTINENT INFORMATION/ MEDICAL RECORDS TO:**

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\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date