

# Beverly Hills Digestive Care

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## Release of Records Authorization

To : \_\_\_\_\_

Doctor or hospital

\_\_\_\_\_

Address

### Patient Information:

Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Address: \_\_\_\_\_

I hereby authorize you to release:

My complete records concerning my illness and/or treatment.

The following Records: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness