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DR. FRINE T. ROCA, MD

AMBER LEWIS, PEDIATRIC CRNP

TO: _____

PHONE: _____ FAX: _____

PATIENT NAME: _____ DOB: _____

I HEREBY REQUEST THAT YOU RELEASE THE FOLLOWING INFORMATION FROM MY MEDICAL RECORD FOR THE PURPOSE OF ONE OF THE FOLLOWING:

TREATMENT PAYMENT OTHER

INFORMATION REQUESTED:

- ALL RECORDS
- DEMOGRAPHICS
- ECHO/GXT REPORT
- EKG/EEG REPORT
- PATH/LABS
- PROGRESS/OFFICE NOTES
- RADIOLOGY REPORTS
- VACCINE RECORD
- OTHER: _____

PATIENT/PARENT SIGNATURE

DATE

WITNESS

DATE

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