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Medical Records Release

I, _____ (DOB ____/____/____) authorize the release of my personal medical information listed below.

Please release/disclose the following information:

- Chart Notes
- X-Ray film or disc (please send in mail)
- X-Ray Report
- MRI disc (please send in mail)
- MRI Report
- Lab Work and Results
- Surgical Reports
- Pharmacy/Prescription Records
- _____

Records being requested:

To/From

Northwest Foot and Ankle
2701 NW Vaughn, Ste 424
Portland, OR 97210
Phone: 503.243.2699
Fax: 503.243.2698

To/From:

Phone #: _____

Fax #: _____

Patient
Signature _____ Date _____

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