

*De Vito and Alvarado Pediatric Associates PLLC*

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**RECORD RELEASE AUTHORIZATION**

**TO:** \_\_\_\_\_  
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**I HEREBY AUTHORIZE AND REQUEST YOU TO RELEASE RECORDS TO:**

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**PLEASE RELEASE ALL MEDICAL RECORDS IN YOUR POSSESSION**

**DURING THE PERIOD FROM \_\_\_\_\_ TO \_\_\_\_\_.**

**PATIENT NAME:** \_\_\_\_\_

**DATE OF BIRTH:** \_\_\_\_\_

**ADDRESS**  
\_\_\_\_\_  
\_\_\_\_\_

**SIGNATURE:** \_\_\_\_\_

**RELATIONSHIP:** \_\_\_\_\_ **DATE:** \_\_\_\_\_