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MEDICAL RECORDS RELEASE

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

FROM:

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

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

SOCIAL SECURITY: \_\_\_\_\_

I voluntarily request that my medical records be released from your office to  
Lubbock Eye Clinic.

\_\_\_\_\_  
Signature of Patient