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MEDICAL RECORDS RELEASE REQUEST

TO: Fair Oaks Women's Health
625 S. Fair Oaks Ave.
Suite 255, South Lobby
Pasadena, CA 91105

Patient Name: _____

Address: _____

Telephone: _____

Fax Number: _____

Date: _____

Please release a copy of my medical records, especially records regarding the following:

To: _____

Thank you very much,

Signature

Printed Name

Date

Note: use this form to request that we send copies of your
medical records to another doctor, clinic or hospital

****There is a \$20 fee for this service, intended to cover the costs of supplies and employee time spent****