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Steindler.com

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REQUEST FOR RELEASE OF MEDICAL RECORDS

To: _____
(Physician Name)

Fax Number: _____

I authorize the above named provider to disclose and deliver to Steindler Orthopedic Clinic the following information:

Name of Patient

Date of Birth

Patient or Authorized Representative Signature

Date (Expires 30 Days After Signature)

If signed by Patient Representative, state authority to act on behalf of patient:

Please fax to Steindler Orthopedic Clinic at (319) 338-0522.

If you have any questions regarding this request, please call us at (319) 338-3606.

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