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RECORDS RELEASE AUTHORIZATION

I hereby authorize:

SAADAT H. ANSARI, M.D.

to release my complete medical records to:

_____
PHYSICIAN

_____
STREET

_____
CITY STATE ZIP

I give my permission to have reports and medical records faxed.

_____
Patient Name

_____
Date of Birth

X _____ _____
Patient Signature Date

_____ _____
Witness Date