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Consent for Release of Information

Please Print

Patient Name Date of Birth

Address

Request:

_____ Request Records from outside facility sent to DNHC

Name of Facility

Address & Fax #

_____ Request DNHC records sent to:

Name of Facility / Doctor

Address & Fax #

Records Requested: _____

I agree to the above request of my medical records release:

Patient Signature

Date

Parent/Guardian signature if patient under age 18

Date