Penn Medicine
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Montgomery Internal Medicine

Diplomates, American Board of Internal Medicine
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Medical Records Release Form

Name of Physician/Practice releasing records.

_____

Address: _____

Phone#: _____ Fax#: _____

Name of Patient:

_____

DOB: _____ Phone#: _____

Please send copies of my records to:

Name of Physician/Practice:

_____

Address:

_____

_____

Phone#: _____ Fax#: _____

Patient Signature: _____ Date: _____

If records requested are more than 10 pages, please mail them to the address indicated above

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