

# G. I. Associates of West Alabama, P. C.

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## AUTHORIZATION FOR MEDICAL RECORDS RELEASE

I hereby authorize GI Associates of West Alabama to release and/or obtain any medical records to:

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Patient's Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Patient's Signature (or parent/guardian): \_\_\_\_\_

Witness Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Special Request:

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