Medical Records Release Form

By signing this form, I authorize to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the physician (In Kwon Park, MD) office.

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| --- | --- | --- | --- |
| Name: |  | DOB: |  |
|  |  |  |  |
| Signature: |  | Date: |  |

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