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**MEDICAL RECORDS RELEASE**

I, \_\_\_\_\_, hereby authorize *Hill Center for*

*Dermatology, PC* to release my medical records to:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Printed Name of Patient: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Patient or Parent/Guardian Signature: \_\_\_\_\_

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

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

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