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Medical Records REQUEST/RELEASE

Patient Name:

Address:

City, State, Zip:

Telephone:

SSN:

Birthdate:

Consent for Release of Medical Information

I authorize: **Seattle Spine & Sports Medicine**

Providers: **Hannah Cho MD / Richard Seroussi MD / Benjamin Snyder MD / Joseph Wilmhoff ARNP**

To (Check one or both):

REQUEST my medical information FROM:

RELEASE my medical information TO:

Patient Signature:

Date: