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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Date: _______________

To: ___________________________________

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I hereby authorize you to release or make available all medical records or reports relating to my care to Dr. Ilkcan Cokgor.

Patient Name (print): _________________________________

Patient signature: ____________________________________

Date of Birth (MM/DD/YYYY): _________________________

Patient phone #: ______________________________

Address: ____

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