AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I, ____ REQUEST THAT
(Patient's name)

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RELEASE MY MEDICAL RECORDS FROM THE FOLLOWING DATES OF SERVICE:

____

TO:

Vein Clinics of Hawaii
RANDALL JULEFF, MD

PATIENT'S SIGNATURE____

DATE OF BIRTH: ______________________ **SOCIAL SECURITY #:** ______________________

TELEPHONE #: ____

DATE OF REQUEST: _________________________________