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***** IN ORDER TO RETRIEVE ANY PREVIOUS MEDICAL RECORDS, PLEASE FILL IN THE NAME OF YOUR LAST MD AND HIS/HER ADDRESS AND SIGN AT THE BOTTOM OF THE PAGE. YOUR SIGNATURE WILL ENSURE THAT RECORDS ARE SENT TO THIS OFFICE.

DATE:_____

PATIENT NAME:_____

DOB:_____

PREVIOUS MD NAME:_____

MD FULL
ADDRESS_____

PLEASE RELEASE PERTINENT INFORMATION AND/OR MEDICAL RECORDS IN REGARDS TO THE ABOVE NAME PATIENT TO MY OFFICE AT THE ABOVE ADDRESS AS SOON AS POSSIBLE.

THANK YOU FOR YOUR TIME AND COOPERATION.

SINCERELY,
FREDERICK J. PIWKO, M.D

_____
PATIENT, PARENT OR GUARDIAN SIGNATURE

_____
WITNESS SIGNATURE