

COLORECTAL SURGICAL & GASTROENTREROLOGY  
ASSOCIATES, PSC

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**Medical Record Release Form**

This request is for the:

Colorectal Surgical Division

Gastroenterology Division

Endoscopy Division

Patient Name:

Patient's Date of Birth:

I, \_\_\_\_\_, hereby authorize

Name:

Address:

City/State:

Zip Code:

Phone:

Fax:

Email Address:

To release my medical records to:

Signature of Patient/Parent or Guardian:

Date: