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Faxed to: _____

Date faxed: _____

Fax Number: _____

Date: ____ / ____ / ____

Re: Request of Medical Records

Patient Name: _____

DOB: _____ Social Security: _____

I hereby request that release:

To:

Pejman Kharazi, M.D

Guardian Signature

Date: ____ / ____ / ____ Patient/Legal