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CONSENT TO RELEASE MEDICAL INFORMATION

Patient Name: _____

Date of Birth: _____

Patient Address: _____

I, _____, hereby consent to the release of the following information from my medical records by _____ to Marlton Nephrology and Hypertension at the above address or fax.

This consent expires on_____

- Laboratory Results
- Radiology Reports
- Operative Reports
- Consultation/Office Notes
- Other requested reports

Signature_____Date_____