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RECORDS RELEASE

To: _____

Date: _____

Re: _____

I hereby authorize and request you to release to: Dr. Eric Wruck DC, FNP
845 Alder Creek Drive
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My: Medical Records _____
X-Rays _____
X-Ray Reports _____
WC-2's _____
Insurance inform. _____
Other: _____

which are in your possession, concerning my illness and/or treatment during the period from, _____
to _____.

Signed: _____
(Patient, Legal Guardian, or Representative)