

Arizona Hand and Wrist Specialists

SURGERY OF THE HAND, WRIST, ELBOW AND MICROSCOPIC SURGERY

A Division of OSNA
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RECORDS RELEASE

DATE _____

DATE OF BIRTH _____

I, _____ HEREBY AUTHORIZE

TO RELEASE ANY INFORMATION REQUIRED IN THE COURSE OF MY
TREATMENT TO:

NAME _____

ADDRESS _____

PHONE _____

FAX _____

PATIENT'S SIGNATURE _____

WITNESS _____

PATIENT'S ADDRESS _____

PATIENT PHONE _____

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