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Gary P. Jones, MD, FACS

RECORDS RELEASE AUTHORITY

I hereby authorize and request you to release
the complete medical records in your possession
concerning my illness and/or treatment during
the period from _____ to present.

Please send information to: _____

_____

_____

_____

Patient Name: _____

Date of birth: _____

Address: _____

_____

_____

Home Phone: _____

Social Security Number: _____

Patient Signature: _____

Date: _____