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Medical Records Release Form

I, _____ give permissions for the office of _____ to release all medical records to California Advanced Pain Institute.

Please fax them to (909) 287-7470 or mail them to the above address. If you have any questions, please feel free to call our office at (909) 287-7474.

SSN#:_____ DOB_____

Patient Signature: _____ Date:_____

_____ Patient in office, please rush! Thank You!

_____ Patient has an appointment on _____