Lee F. Carter, M.D., F.A.C.C., Inc.

Cardiology

Medical Records Release

Date:______________________________

Patient Name:____ DOB:_____________

To:____

Address:____

Please send the following records to: Lee F. Carter M.D., Inc.

Records Requested:____

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Please accept this as authorization to release medical, psychiatric, drug, alcohol and HIV information also.

____
Patient or Responsible Party Signature

____
Witness/Relationship

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