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"Providing high quality healthcare for all stages in a woman's life"

Records Release Authorization

TO: ____

ADDRESS: ____

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I, __________________________________ with SSN # __________ and

DOB ______________ , request the release of the complete records in your possession concerning my medical history and treatments received while under the care of your practice, or from ______________ to ________________, to Dr. Eleni Solos-Kountouris.

Signature: _____________________________ Date: __________

Witness: _____________________________ Date: __________

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