



Dedicated to Women
OB-GYN

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MEDICAL RECORD RELEASE REQUEST

I authorize _____
Releasing Physician Name

Physician's Phone Number Physician's Fax Number

to release my medical information, including the diagnosis and records, of any treatment or examination rendered to me during the period from _____ to _____.

These records are to be released to:

**Dedicated to Women OB-GYN
200 Banning Street Ste 320
Dover, DE 19904
302-674-0223**

Print Name: _____

Date of Birth: _____

Signature: _____

Date: _____

Phone Number: _____

Witness: _____

Dedicated to Women OB-GYN Employee

Please Note: Any charges for the processing of this request are the patient's responsibility. The patient is also responsible to verify that her records have been sent to Dedicated to Women OB-GYN prior to her appointment with one of our providers.