

Allison Paige Young, M.D. // Jana Waters, M.D.

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**REQUEST FOR MEDICAL RECORDS**

Please send a copy of this patient's complete ophthalmic to: **Allison Paige Young M.D. //**

**Jana Nicole Waters, M.D.** or OTHER medical records

I hereby authorize: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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to disclose the above information to Allison Paige Young, M.D.// Jana Waters, M.D., in furtherance of this authorization, I do hereby waive all provision of law and privileges relating to the disclosures hereby authorized.

Dated this \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ day of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, 20\_\_\_\_\_\_

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Patient's name (please print)

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Patient’s Date of Birth

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Patient's signature (or responsible party)