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**RECORD RELEASE AUTHORIZATION**

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WILLIAM J. WEISSINGER, DPM.,D.A.B.P.S.  
488 NEW YORK AVNEUE  
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THE COMPLETE HISTORY RECORDS IN YOUR POSSESSION,  
CONCERNING MY ILLNESS AND OR TREATMENT / XRAYS  
DURING THE PERIOD

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PATIENT NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

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D.O.B. \_\_\_\_\_

PATIENT SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

WITNESS: \_\_\_\_\_