THE MAGNOLIA MEDICAL GROUP

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REQUEST FOR MEDICAL RECORDS
DR VINCENT GALIANO, MD

Date: _____

To: _____

Phone: _____

Fax: _____

Patients
Name: _____

DOB: _____

SS#: _____

I hereby request the following records to be released to:

Name: _____

Phone: _____

Fax: _____

Patient signature: _____

Date: _____