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OBSTETRICS AND GYNECOLOGY
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Records Release

Patient Name: _____

Social Security #: _____

Date of Birth : _____

Release Records From: _____

Attn: MEDICAL RECORDS DEPARTMENT

I hereby authorize and request that you release to:

Nigel A. Spier, MD FACOG
3990 Sheridan Street
Suite 207
Hollywood, FL 33021
Phone: 954-518-0094
Fax: 954-518-0098

The complete medical records in your possession concerning my illness and/or treatment during the period from:

Patient Signature _____

Witness _____

Date _____