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MEDICAL RECORDS RELEASE

TO: _____

I hereby authorize you to release to:

Matthew A. Fitzer, M.D.
Virginia Bariatric Surgery, P.C.
171 Elden Street, Suite 3B
Herndon, VA 20170

- ☐ All Information
- ☐ Any information including the diagnosis and records of any treatment or examination rendered to me during the period:
From _____ To _____

WITNESS

PATIENT'S SIGNATURE

DATE

PATIENT'S NAME (PRINT)