



Release of Medical Records

GENE W. ZDENEK, MD

Medical Director

Name: _____

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Date: _____

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Date of Birth: _____

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I, _____, authorize the release of all my medical records in your possession to:

Gene W. Zdenek, M.D.

Vial snail mail at:
7012 Reseda Blvd Suite B
Reseda, Ca 91335

Or facsimile at:
818_342_3937

Patient Signature

Date

Print Name