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TO REQUEST YOUR MEDICAL RECORDS via e-mail:

Patient Name _____

Date of Birth ____/____/____

Medical Record # (if available) _____

Last 4 digits of Social Security # XXX-XX-____ (please do not email your full SS #)

Type of Study _____

Date of Service ____/____ (month and year)

Daytime telephone# (____)-____-____

Requested by Dr. _____

Images on: Film (\$100.00 each) CD (\$30.00 each) Paper (\$5.00 each; color \$10.00 each)

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