BellaDonna Medical PC

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MEDICAL RECORDS RELEASE

I, ______________________________, authorize **Dr. Shawn I. Yunayev/BellaDonna Medical PC, 6410 Veterans Avenue, Suite 103, Brooklyn NY 11234-5605** to release my individual identifiable health information to myself.

I understand that I am responsible to pay seventy five cents **(.75**) per page.

Name:____

Address:____

City, State ZIP:____

Comments:

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Signature of Patient   Date