



CALIFORNIA CANCER CARE, INC.  
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\_\_\_\_\_  
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**RECORD RELEASE FORM**

Date \_\_\_\_\_

To \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I hereby authorize my records to be released to \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Any information including diagnosis, treatment, or any examination rendered to me during the period  
from \_\_\_\_\_ to \_\_\_\_\_

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
WITNESS

\_\_\_\_\_  
PRINT NAME