



Vineyard Medical Clinic

VINEYARD MEDICAL CLINIC- WESTWINDS

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Consent to Release Charts

I, give the Vineyard Medical Clinic authorization to release my

_____ to _____. I am aware that
once my charts have been release that The Vineyard Medical Clinic is no longer
responsible for the distribution or disclosure of said medical records.

Date: _____

Patient's Signature: _____

Witness' Signature: _____