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www.houstonmds.org

CARDIOVASCULAR RECORDS REQUEST

Date:

Doctor/Clinic/Hospital

Your Name:

DOB:

Please forward copies of my medical records related to my treatment rendered by you or under your supervision from _____ through _____.

Please fax the information to:

James M. Wilson, M.D.

6560 Fannin, Suite 1836

Houston, TX 77030

Fx (713)790-1605

Printed,

Signed,
