

Crossroads Medical Associates, LLC

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Family Practice
Internal Medicine
Preventive Medicine
Aviation Medicine

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Irwin H. Moss, M.D.
1928 - 1989

RECORD RELEASE

Date: _____

To: _____

Patient: _____

Address: _____

Date of Birth: _____

I hereby authorize you to release to **CROSSROADS MEDICAL ASSOCIATES, LLC** any information including the diagnosis and records of any treatment or examination rendered to me during the period from _____ to _____.

Signature

Witness