SHADY GROVE OPHTHALMOLOGY™

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Date: _____

To Whom It May Concern:

_____, is requesting release of his/her medical records.

Date of Birth: _____.

Please send to :

Dr. Anthony Roberts

9715 Medical Center Drive #502

Rockville, Md. 20850

301-279-2770

Or fax to us at: 301-294-5322.

I approve release of the records

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