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Please give us information on past or current physicians, therapists or facilities that we may need to request medical records from.

1. Physician: _____

Address: _____

City/St./Zip: _____

Telephone: _____

2. Physician: _____

Address: _____

City/St./Zip: _____

Telephone: _____

3. Physician: _____

Address: _____

City/St./Zip: _____

Telephone: _____

4. Physician: _____

Address: _____

City/St./Zip: _____

Telephone: _____