

**SALEEBY & WESSELS**  
**PROCTOLOGY**  
BOARD CERTIFIED COLON AND RECTAL SURGEONS

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Re: Medical Records

I, \_\_\_\_\_, DOB, \_\_\_\_\_  
give permission to Saleeby and Wessels Proctology to release my medical records to me or  
my physicians:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Telephone: \_\_\_\_\_

Fax: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness \_\_\_\_\_