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OLOGYMED

STAT FAX REQUEST

DATE:_____

To: _____ From: _____

Fax: _____ Fax: _____

Phone:_____ Phone:_____

_____ _____

Print Patient Name Date of Birth

I, _____ allow Ologymed to receive/send any and all
SIGN

information/records including previous/current notes, test results, imaging, labs, etc.

Notes: