Patient Release of Information



Deborah McGrew MD, OT 3225 California Ave SW, Seattle, WA 98116 P 206-241-4646, F 206-933-2049,

outsidetheboxpediatrics@gmail.com,

Patient Name:			DOB:	
First		Last		mm/dd/yyyy
To:				
Address:				
Street		City	State	Zip
Phone:		Fax:		
Email:				
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my child		between the above listed Dr. /Professional and		
Dr. Deborah McGrew	with the follow	ving restrictions (if any) listed helow	
DI. Debolali McGlew	with the follow	ville restrictions (if any	, listed below.	
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Expiration date:				
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