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| **Medical Fax Cover Sheet** |
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| **[ENTITY NAME]** |  |  |  |  |  |  |
| [ENTITY ADDRESS] |  |  |  |  |  |  |
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| Date: |  |  |  |  |  |  |
| Cover Sheet + Pages: |  |  |  |  |  |  |
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| **To** |  |  |  |  |  |  |  |
| Name: |   |
| Address: |   |
| Phone No.: |   |
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| **From** |  |  |  |  |  |  |  |
| Name: |   |
| Address: |   |
| Phone No.: |   |
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| **Comments** |  |  |  |  |
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| Enclosed herein are confidential patient information. Medical information is personal and sensitive. Please maintain the confidentiality of such information. Unauthorized disclosure of any of the sensitive information would subject you penalties under Federal and State Law. |
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