



**Robert W. Ullman, N.D. and Judyth Reichenberg-Ullman, N.D., M.S.W.**

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**RELEASE OF MEDICAL RESPONSIBILITY**

I have received my medical records from Dr. \_\_\_\_\_  
or have requested that my records be sent to Dr. \_\_\_\_\_  
and hereby acknowledge that I am no longer receiving medical care from Dr. Robert  
Ullman or Dr. Judyth Reichenberg-Ullman.

\_\_\_\_\_  
Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date