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PATIENT INFORMATION RELEASE AUTHORIZATION

Patient Name: _____ DOB: _____

Because of Privacy laws, no one other than yourself is able to have access to your personal medical information. If you would like someone other than yourself to have access to your medical information, please fill out their name and relationship to you below. This consent form is considered valid unless revoked in writing or a new form is submitted.

I authorize the following individuals to have access to information regarding my medical care/treatment.

Name

Relationship

Signature of Patient/Guardian

Date