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# PATIENT AUTHORIZATION FOR RELEASE OF RECORDS

PRINT ALL INFORMATION, SIGN AND DATE AT THE BOTTOM

## INDIVIDUAL PATIENT (OR PERSONAL REPRESENTATIVE) CONFIRMING THE AUTHORIZATION

* PATIENT NAME: .
* DATE OF BIRTH: .

# THE USE OR DISCLOSURE AUTHORIZED

NAME THE PEOPLE AND\OR ORGANIZATION THAT YOU ARE AUTHORIZING TO USE AND\OR TO DISCLOSE THE PROTECTED HEALTH INFORMATION DESCRIBED ABOVE:

* NAME: .
* ADDRESS: .
* FAX NUMBER: .

## SPECIFIC INFORMATION TO BE RELEASED:

. .

## SIGNATURE OF PATIENT(REPRESENTATIVE) DATE SIGNED:

. . . .

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