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Authorization To Release Information

Date: _____

I hereby authorize the disclosure of my health information as follows:

Pt. name: _____

Date of Birth: _____

Person(s) or organization(s) to use or disclose information (name, phone, fax, email):

I understand this information applies only to health information relating to medical history, mental or physical condition, and treatment received. This authorization expires in one year and I may revoke this authorization at any time.

Name: _____

Signature: _____

Date: _____