Authorization for Medical Information Release

I, ______________________________ authorize release of my medical information to:

Print Name

______________________________	______________________________
Name	Relationship(Spouse, Mother, Father, etc.)
______________________________	______________________________
Name	Relationship(Spouse, Mother, Father, etc.)
______________________________	______________________________
Name	Relationship(Spouse, Mother, Father, etc.)

☐ No one other than myself can have access to my medical information

(**Please check this box if we can only speak to you**)

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Patient Signature

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Date