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AUTHORIZATION FOR DISCLOSURE OF MEDICAL RECORDS

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I hereby authorize the release of medical information to include diagnoses, progress notes, lab results, treatment or examination rendered to me to:

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\_\_\_\_\_  
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\_\_\_\_\_  
Patient Signature                      Date

\_\_\_\_\_  
Signature of Witness                      Date