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RELEASE OF MEDICAL RECORD INFORMATION

PATIENT NAME _____

PATIENT DOB: _____

I do **not** give permission for information pertaining to my medical history released to another family member.

I **do** give permission for my medical information to be released to the following:

NAME

RELATION TO ME

Do you want us to leave information regarding your medical history on your answering machine?

Yes _____ No _____ What number do you want us to call? _____

Patient Signature _____

Date _____