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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: [DOB]:

Previous Name: Social Security #:

I request and authorize ______________________ to release healthcare information of the patient named above to:

Name:________________________________

Address:______________________________

____

Phone: (   )   -

Fax: (   )   -

This request and authorization applies to:

○ Healthcare information relating to the following treatment, condition, or dates

○ All healthcare information ○ Other

Patient Signature: ____ Date signed: [Date]