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**AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION**

Patient name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Phone: \_\_\_\_\_

I request and authorize \_\_\_\_\_ to release health care information of the patient named above to:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone number: (    ) \_\_\_\_\_

\_\_\_\_\_  
Signature of patient or patient's authorized representative    /    Date signed