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AUTHORITY TO RELEASE PERSONAL HEALTH INFORMATION / MEDICAL RECORDS

ADDRESS:		
DATE OF BIRTH:	/ /	
REQUEST DOCTOR:		
DOCTOR:		
ADDRESS:		
PHONE:	FAX:	
ADDITIONAL FAMILY MEMBERS:		
NAME: Male Female	Date of Birth:	1 1
NAME: Male Female	Date of Birth:	<u> </u>
NAME: Male Female	Date of Birth:	<u> </u>
NAME: Male Female	Date of Birth:	/
TO RELEASE MY/OUR HEALTH INFORMATION/MEDICAL RECORDS TO DOCTOR:		
DOCTOR'S NAME:	AT CASEY FAMILY PRACTICE.	
POSTED/FAXED BY STAFF:		
SIGNATURE OF PATIENT:	DATE:	1 1

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