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Medical Information Release Form
(HIPPA Release Form)

I _____ authorize disclosure of information regarding my billing, condition, treatment and prognosis to the following individual(s):

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Signature of patient: _____ Date _____

Signature of Parent if a minor: _____ Date _____