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Persons Authorized to Receive Medical Information

I hereby authorize the following person(s) to receive medical information concerning my general medical care and treatment.

Name _____ Relationship: _____

Home Phone: _____ Work/Cell: _____

Name _____ Relationship: _____

Home Phone: _____ Work/Cell: _____

Name _____ Relationship: _____

Home Phone: _____ Work/Cell: _____

Name _____ Relationship: _____

Home Phone: _____ Work/Cell: _____

Patient's Name: _____

Signature: _____Date: _____