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**Disclosure Authorization**

I authorize the doctors and office staff to disclose my medical information to the following people (please list the names and relationships of any family, friends, etc. who may request information on your behalf):

Name	Relationship
_____	_____
_____	_____
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X

\_\_\_\_\_  
Printed Name of Patient or Guardian

X

\_\_\_\_\_  
Signature of Patient or Guardian

X

\_\_\_\_\_  
Date