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PLLC

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Release of Records Authorization

I hereby expressly and irrevocably waive, on behalf of myself and my personal representatives, all provisions of law prohibiting any physician or other person who has attended or examined me from disclosing any and all knowledge or information which was thereby acquired. A Photostat of this authorization shall be considered as effective and valid as the original.

Patient's Signature _____Date: _____
(or guardian if a minor)

Patient's Name: _____

Witness: _____Date: _____

Records sent to Dr. _____