

**Permission to Release Medical Information
For Ages 18 and Up**

(must be completed by all patients age 18 and older)

I, _____, give my permission for the following adult(s):
Adult Patient Name (please print)

_____ Name	_____ Relationship to Patient
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_____ Name	_____ Relationship to Patient
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_____ Name	_____ Relationship to Patient
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to obtain my personal health information as needed.

Signed: _____ Date of Birth _____

Date: _____ (expires 1 year from this date)