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CONSENT FOR RELEASE OF MEDICAL INFORMATION

DATE: \_\_\_\_\_

I hereby authorize Dr. \_\_\_\_\_ to  
Release to; \_\_\_\_\_ my  
Medical history, laboratory report, X-rays and any other material regarding the medical  
Consultations and treatment which I received.

SIGNED: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

\_\_\_\_\_

RE: \_\_\_\_\_