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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize:

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☐ VALERIA NIETO-GONZALEZ, MSN, APRN, FNP-BC

to release my medical records to include all progress notes, diagnostic studies and consult notes to:

Doctor / Facility / Company: _____

Address: _____

Fax: _____ Phone #: _____

Other: _____

Patients Name: _____ DOB: _____

_____ _____

Patients Signature / Power of Attorney: Date: