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Authorization to Release Medical Information Form

I hereby authorize,

- | | |
|---|---|
| <input type="checkbox"/> JOSEPH J. KATTA, M.D. | <input type="checkbox"/> ROBERT S. EPSTEIN, M.D. |
| <input type="checkbox"/> JEAN HUBER, MSN, ARNP, FNP-BC | <input type="checkbox"/> OLGA MEDINA, MSN, ARNP, FNP-BC |
| <input type="checkbox"/> MANUEL DOMAGTOY, MSN, ARNP, FNP-BC | <input type="checkbox"/> BRENDA DOZACK, MSN, ARNP, FNP-BC |
| <input type="checkbox"/> LISAMARIE SIMMONS, MSN, ARNP, FNP-BC | |

To release my medical records to include all Office Visits, Procedures/pathology, Radiology Reports, Laboratory Reports, and consult notes to:

Doctor/Facility/Company _____

Address: _____

Fax#: _____ Phone#: _____

Date of Service (FROM): _____ (TO): _____

Reasons for requesting medical records: _____
(e.g., continuing care, personal use, legal) _____

Patient Name: _____

Date of Birth: _____ Social Security #: _____

If Authorization is not complete, signed and dated, it may be returned and result in my information not being released until completed.

_____/_____
Signature of Patient/Patient's Personal Representative** Printed Name

_____/_____/_____
Relationship, if not Patient Date Signed

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