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ADDITIONAL DISCLOSURE AUTHORITY

In addition to the allowable disclosures described in the Notice of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the person(s) listed below.

Name _____ Relationship to Patient _____

Name _____ Relationship to Patient _____

Name _____ Relationship to Patient _____

Name _____ Relationship to Patient _____

Date _____

Patient's Name _____

Signature of Patient or Parent/Guardian _____

Relationship to Patient _____