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STANDARD AUTHORIZATION OF USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION

Please print:

I, _____, Date of Birth:_____
(Patient name)

hereby give ***Timarron Family Medicine, PA*** permission to give

_____, _____
(Name) (Relationship to patient)

any, and or all medical information on myself.

Date:_____ _____
(Patient Signature)

_____/_____/_____
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