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BECAUSE WE PROTECT OUR PATIENTS PRIVACY.....

Please provide a list of doctors, family members, friends, pharmacies, etc. that we can release your medical information to. Anyone not on this list will not be able to get any personal or medical information regarding your care.

It is important to understand that this is for your privacy and protection.

Your
Name: _____ DOB: _____

Signature: _____ Date: _____

Please call our office if this list changes at any time.