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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

_____ I HEREBY GIVE AUTHORIZATION TO THE ABILENE EYE INSTITUTE FOR RELEASE OF MY MEDICAL INFORMATION TO THE FOLLOWING PERSON (S):

NAME: _____
RELATIONSHIP: _____
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PHONE: _____

NAME: _____
RELATIONSHIP: _____
ADDRESS: _____
PHONE: _____

_____

PATIENT SIGNATURE (OR PARENT IF A MINOR) DATE REQUESTED

_____

PRINT PATIENT NAME DATE OF BIRTH SOCIAL SECURITY NO.