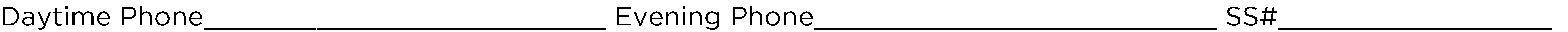
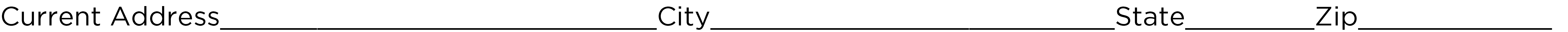
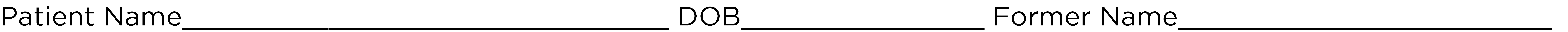
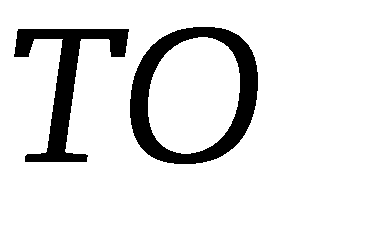
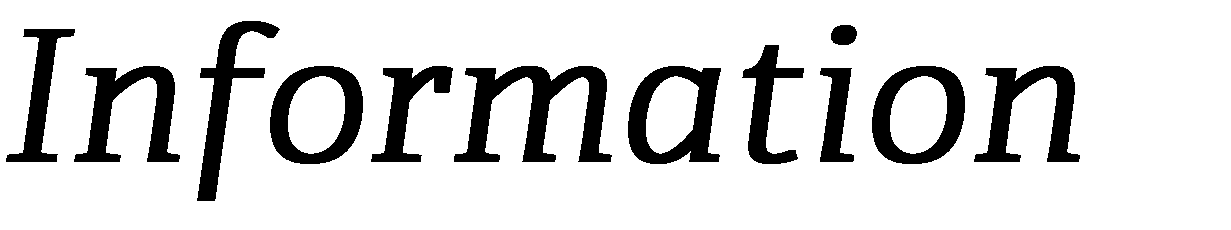
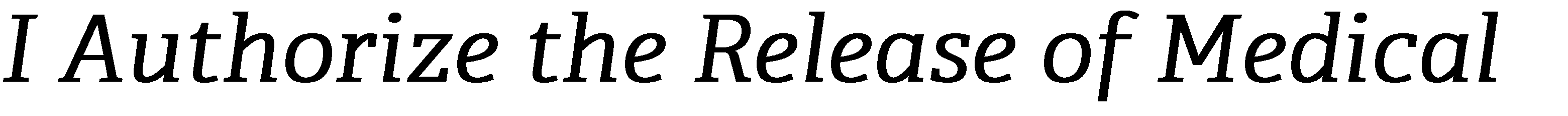
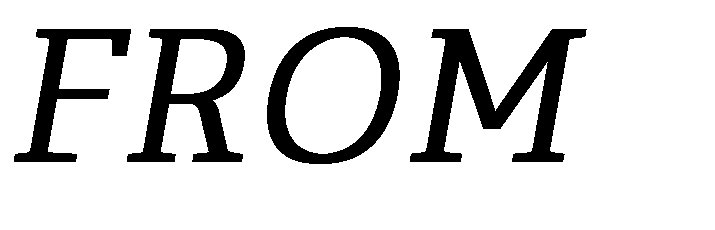
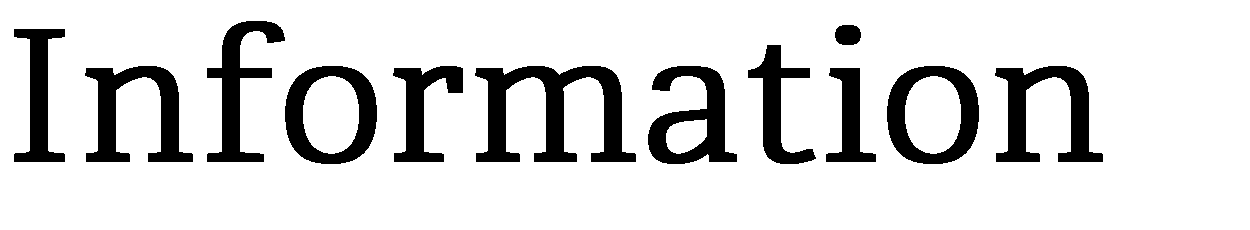
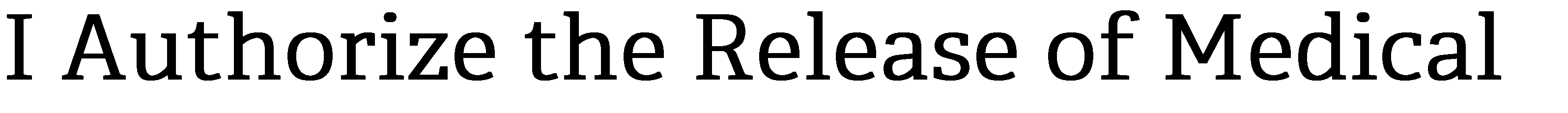
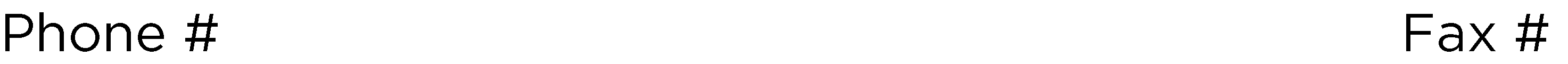
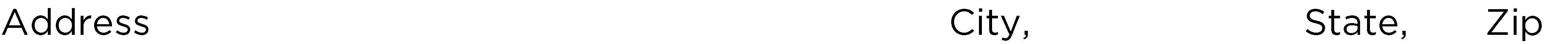
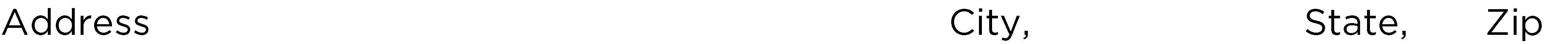
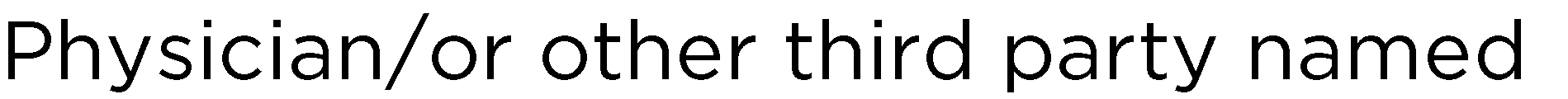
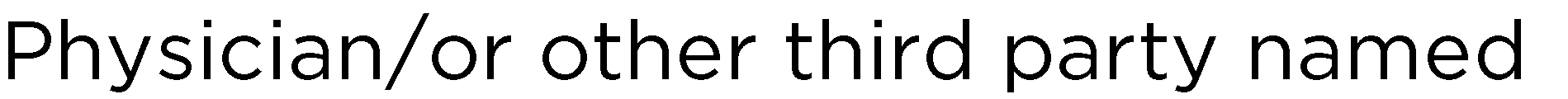
Authorization to Release Medical Information



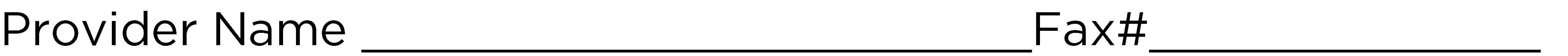


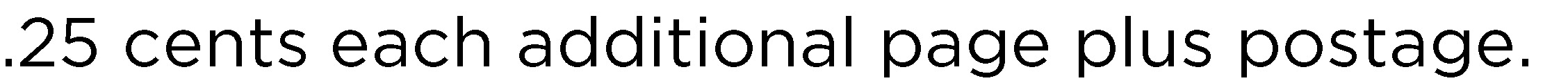
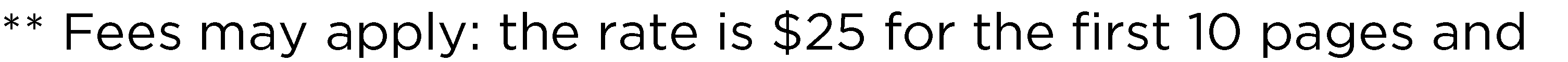
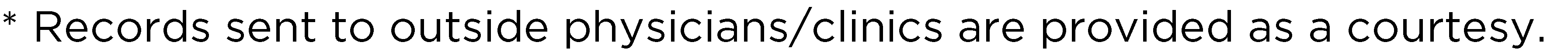
**OR**

**(select one)**

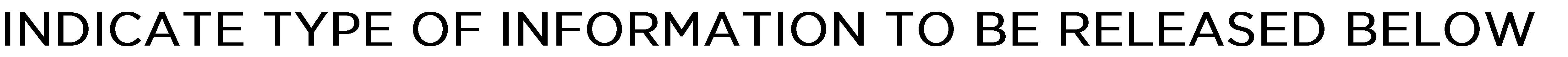


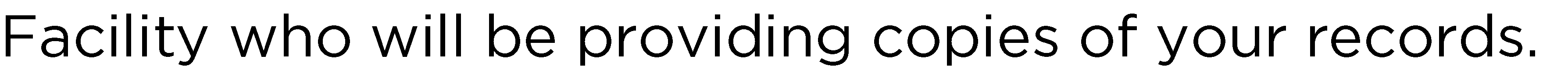
**Please send my medical records/films to:**



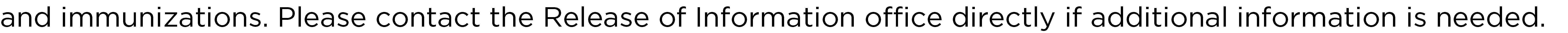
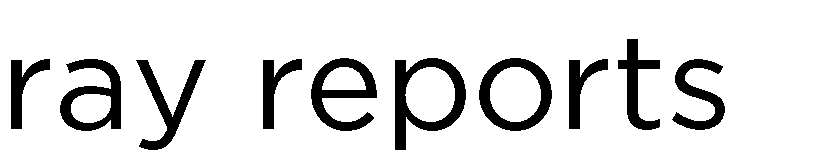
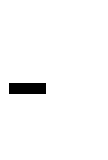
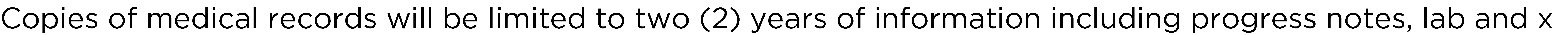
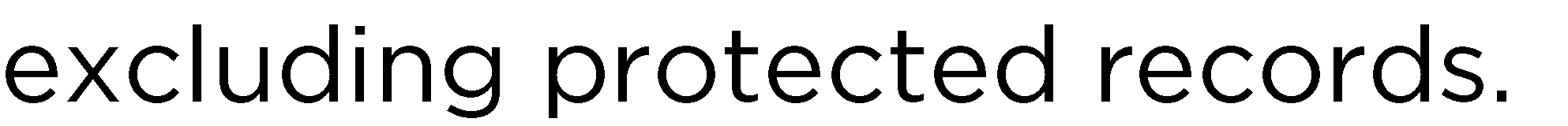
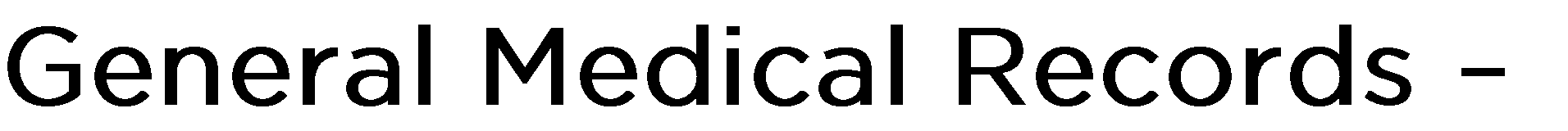


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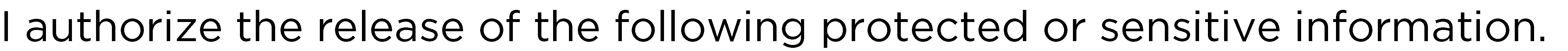
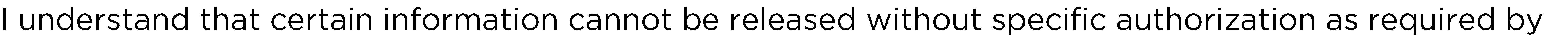
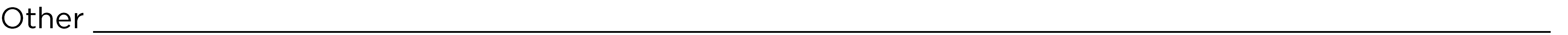
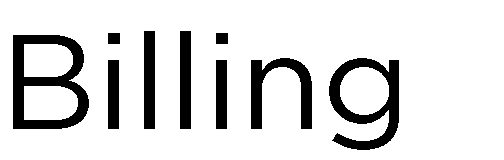
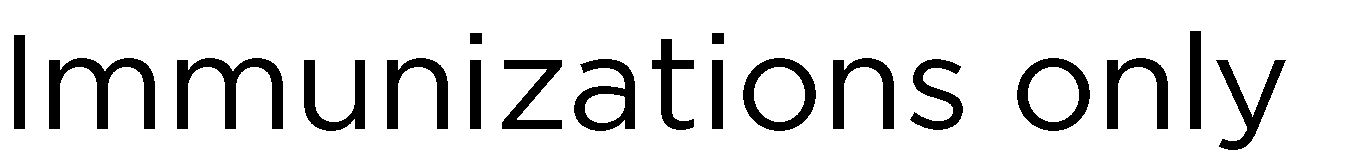
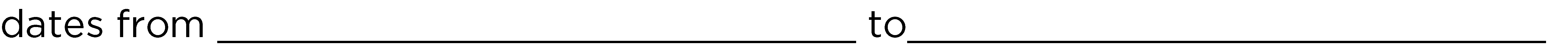
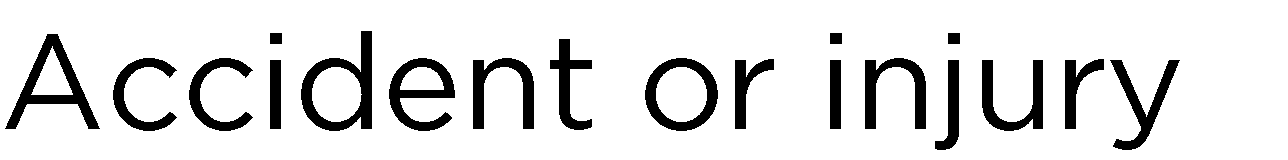
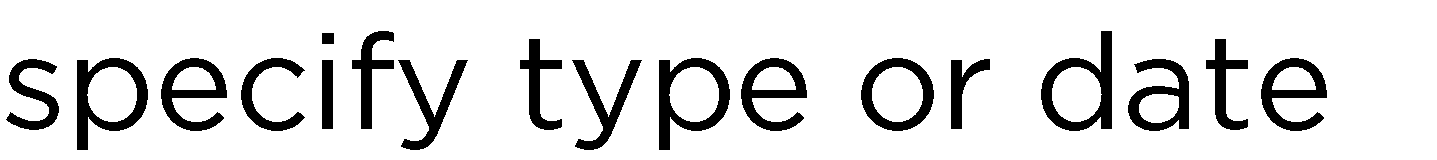
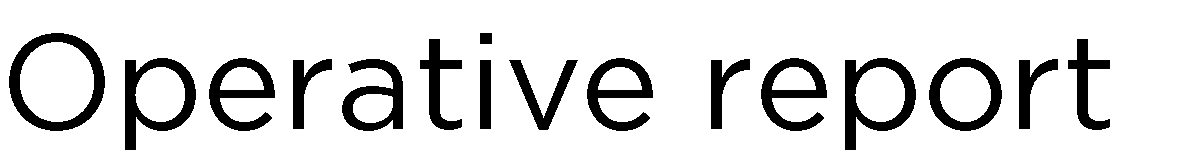
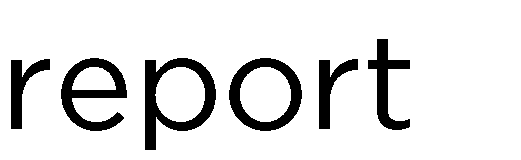
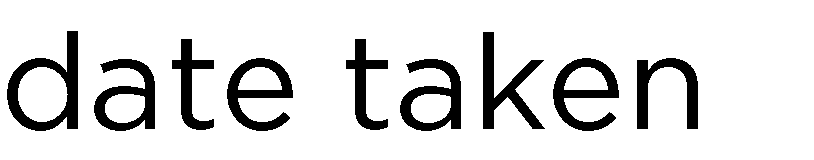
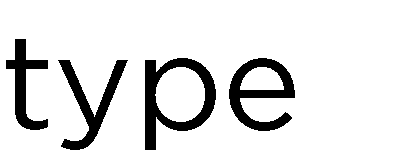
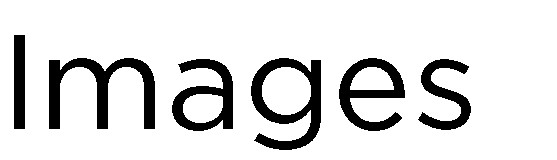
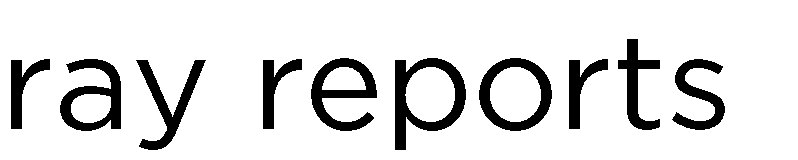
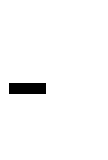
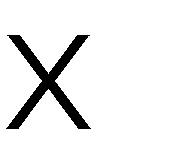
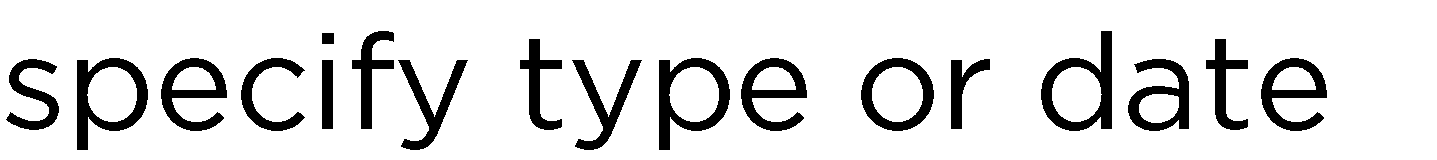
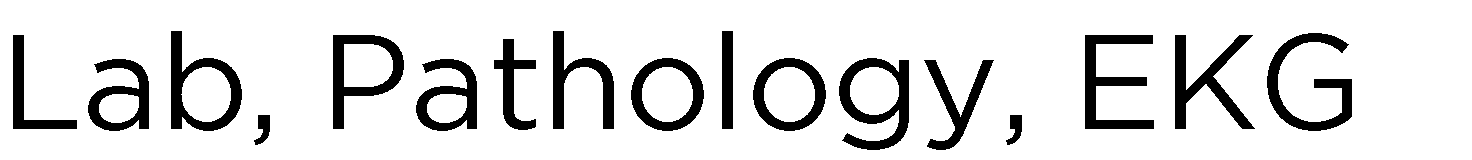
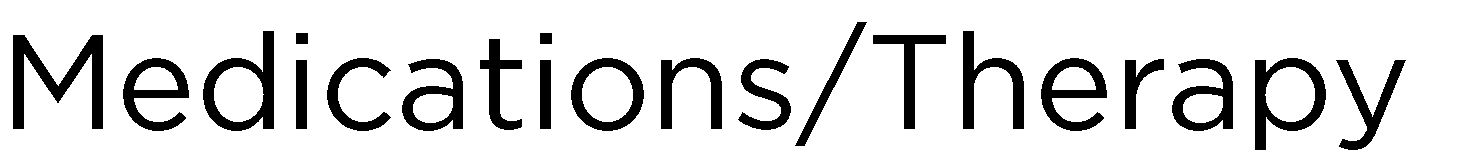
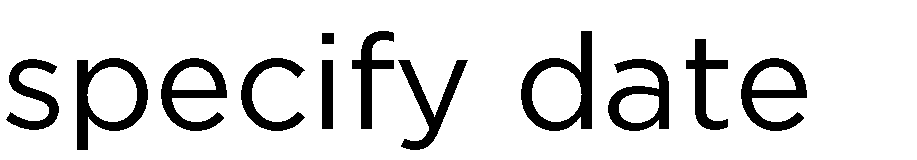
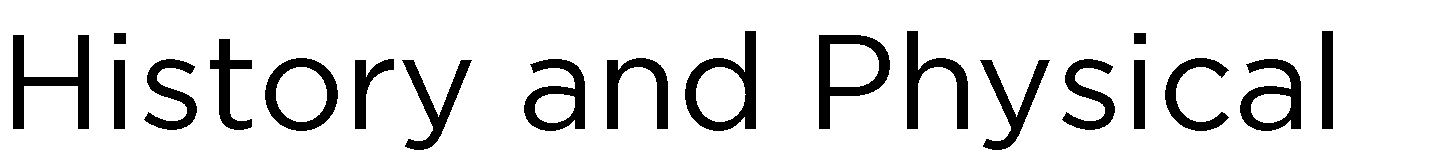
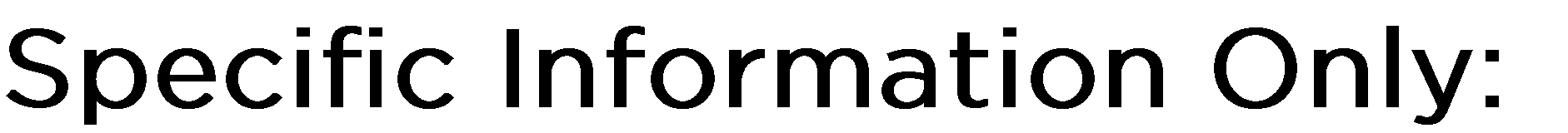




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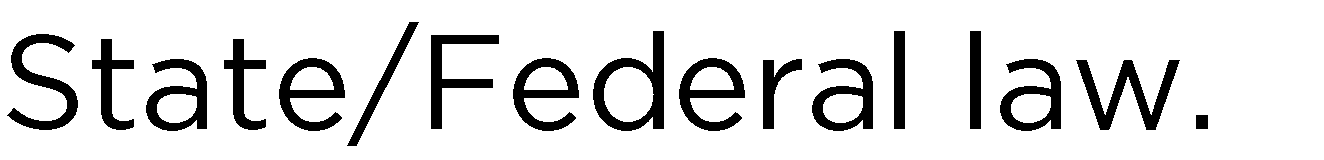


**-OR-**



**Protected or Sensitive information:**

**BY INITIALING**

DRUG ABUSE DIAGNOSIS/TREATMENT ALCOHOLISM DIAGNOSIS/TREATMENT MENTAL HEALTH/TREATMENT

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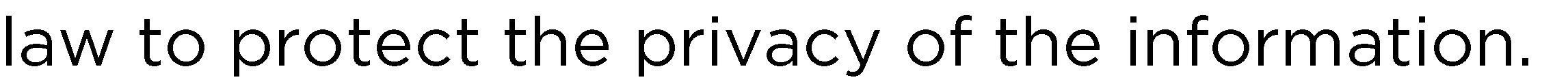
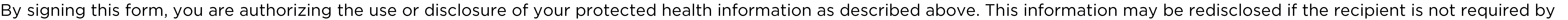
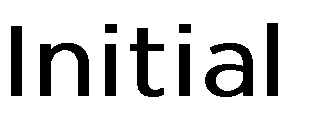
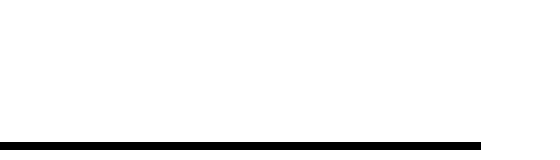
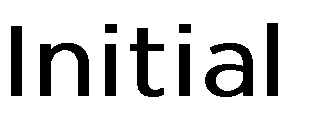
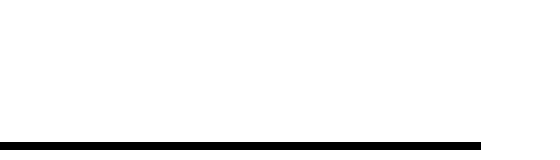
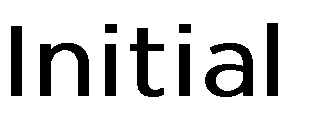
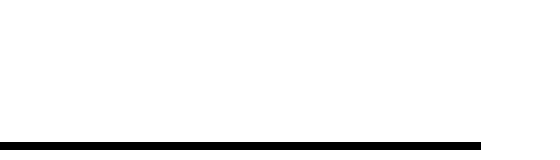
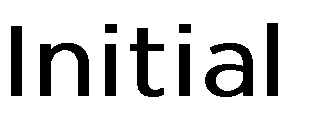
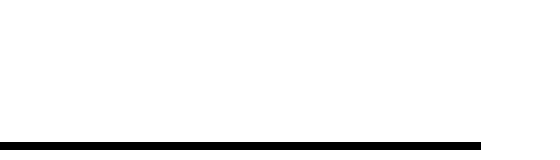
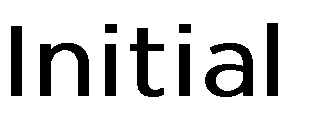
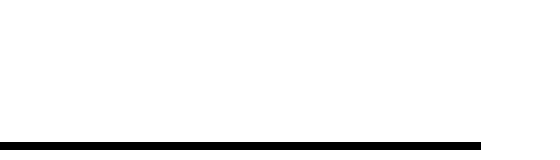
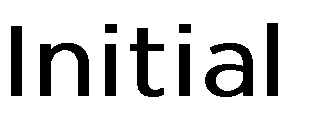
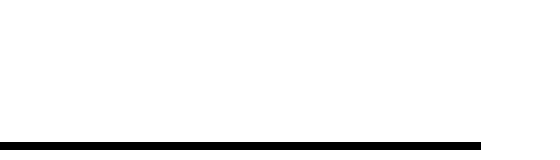
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SEXUALLY TRANSMITTED DISEASES

AIDS/HIV TEST RESULTS INCLUDING RELATED HIGH RISK BEHAVIOR GENETIC TESTING

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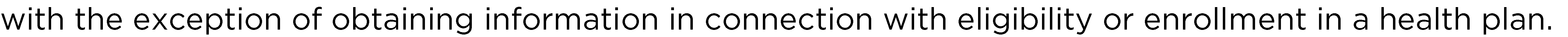
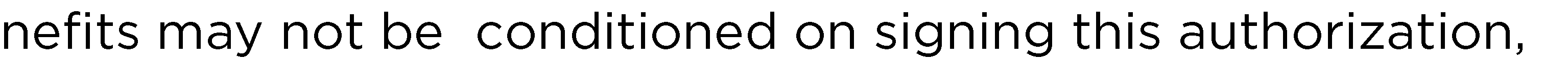
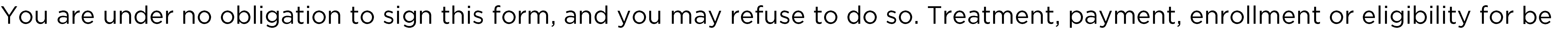
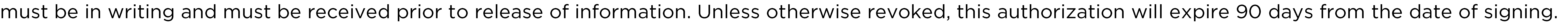
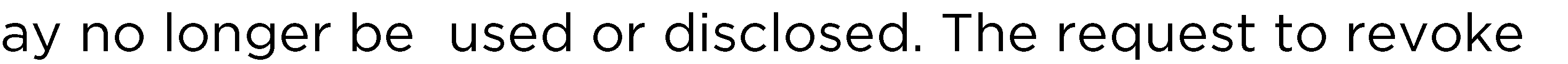
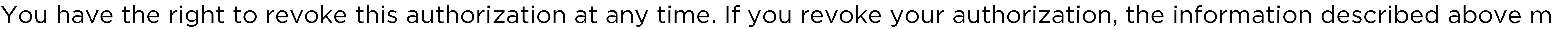
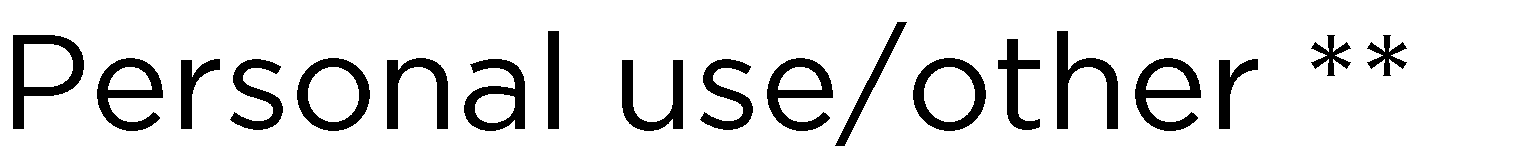
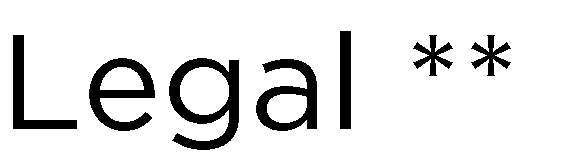
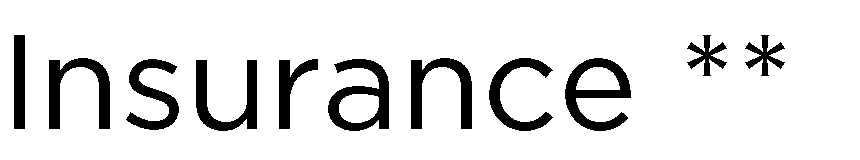
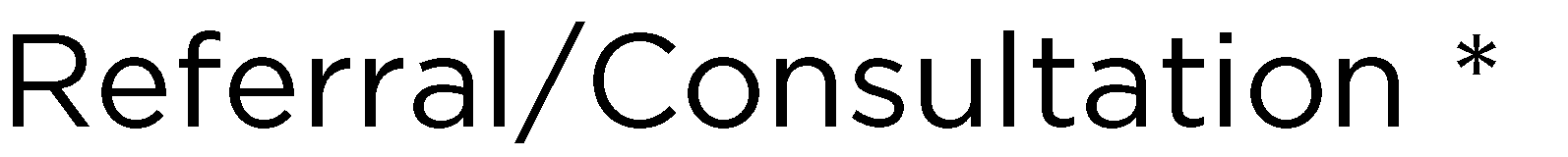
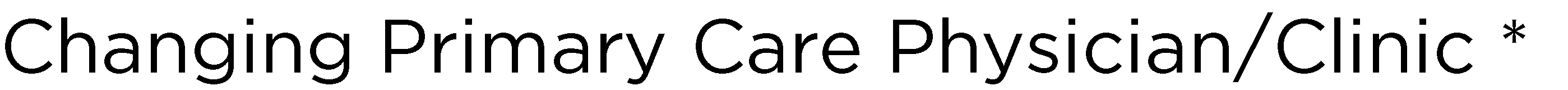
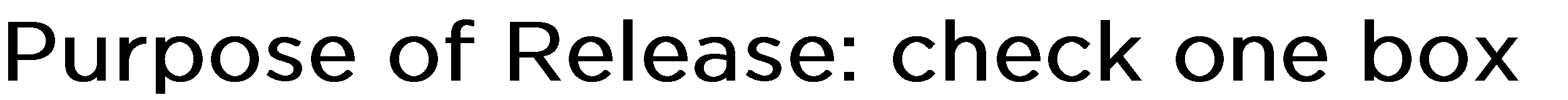
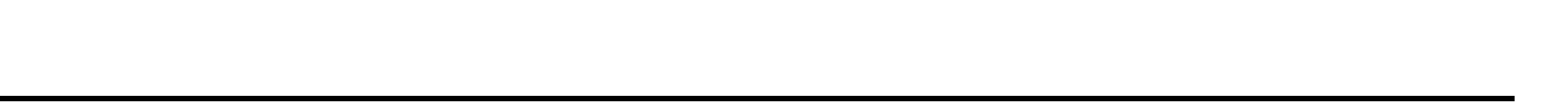
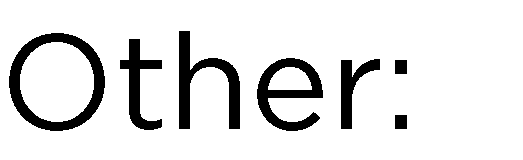
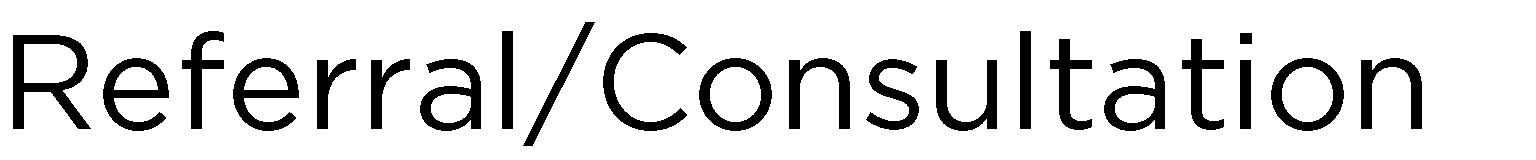
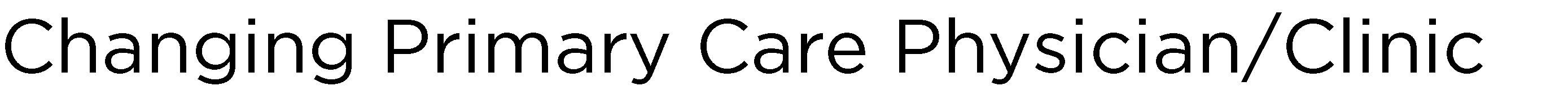
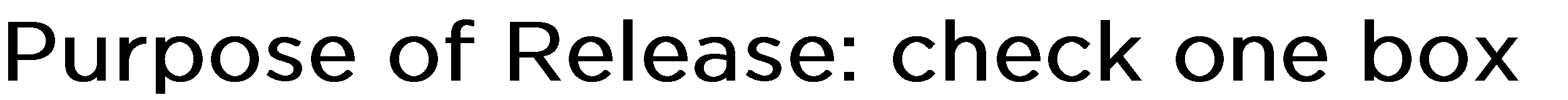
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Signature of Patient or Legally Responsible Person Relationship to Patient Date

