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RELEASE OF MEDICAL INFORMATION

I, (Name) _____ (Signature) _____

(DOB) _____ authorize Boca Raton Psychiatry to discuss all pertinent aspects of my medical and psychiatry care with the following individuals, physicians or hospitals listed below. In addition, I authorize Boca Raton Psychiatry to obtain any laboratory reports, hospital records, diagnostic imaging or medical records deemed necessary for treatment from the providers listed below.

Name _____

Location _____

Phone _____

Fax# _____

For the above named entity, please fax and/or mail any pertinent medical records, last treatment notes or reports in help in providing medical care.

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