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PATIENT MEDICAL RELEASE FORM

Information about you is protected under federal law and you have the right to revoke this Consent, unless we have taken action in reliance on your authorization (as determined by our Privacy Officer). By signing below, you recognize that the protected health information used or disclosed pursuant to the Consent may be subject to re-disclosure by the recipient any may no longer be protected under federal law.

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Signature: _____ Date: _____

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