

**CONSENT TO DISCUSS MEDICAL INFORMATION**

I, \_\_\_\_\_, DOB \_\_\_\_\_, HEREBY

AUTHORIZE \_\_\_\_\_ / \_\_\_\_\_ TO HAVE  
Name Relationship

ACCESS TO ANY AND ALL OF MY MEDICAL RECORDS. THIS INCLUDES,  
BUT NOT LIMITED TO, DOCTORS' NOTES, TEST RESULTS, AND  
PRESCRIPTIONS (WRITTEN, VERBAL, OR ELECTRONICALLY  
TRANSMITTED).

SIGNATURE \_\_\_\_\_

PRINTED \_\_\_\_\_ DATE \_\_\_\_\_

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