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NeuroInterventional MEDICINE

Authorization For Release of Health Information

Patient Name (Last, First, MI) _____

Date of Birth: _____

This Authorization Expires:

When Information is Received _____ In Six Months _____ In One Year _____ In Three Years _____ On Date _____

The Person named above authorizes health information to be requested or released to the following Persons or Entities:

Name, Title, Address, Phone Number:

1._____

_____

2._____

_____

3._____

_____

4._____

_____

5._____

_____

SIGNATURE:_____ DATE: _____