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## **AUTHORIZATION FOR RELEASE OF INFORMATION/RECORDS**

I, \_\_\_\_\_, hereby authorize Dr. Kevin H. Spicer to correspond with \_\_\_\_\_, regarding \_\_\_\_\_ (patient name). I understand that this correspondence may involve a conversation or transfer of written material. I further understand that this consent may be withdrawn at any time.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Witness: \_\_\_\_\_

Date: \_\_\_\_\_