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DATE: ____

PATIENT'S NAME: ____

PATIENT'S DOB: ____

Due to the HIPPAA enactment regarding patient confidentiality issues, we cannot give or discuss information pertaining to your health with anyone other than yourself. If you would like us to be able to discuss your health with someone else (ex: spouse, daughter, son, etc.) please list their name(s) and relationship(s) below.

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This may be revoked by you at anytime.

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Patient Signature