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Medical Information Access Form

DATE _____

PATIENT'S NAME _____ DOB_____

Please list below the name/names of the person/people that have your permission to have access to your medical records and obtain your medical information both verbal and written.

_____ _____
Name Relationship

_____ _____
Name Relationship

_____ _____
Name Relationship

_____ _____
Patient's Name Patient's Signature

Date: _____

_____ _____
Legal Guardian Guardian's Signature
Date

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