Pediatric Gastroenterology & Nutrition of Tampa Bay

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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I, _____ Parent of: _____
(Parent's name) (Patient's Name)

D.O.B. _____ LAST FOUR OF SS# _____

GIVE: _____
_____
_____
_____

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION REGARDING MY MEDICAL STATUS TO:

_____
(Name)

_____
(Address) (Phone)

THE FOLLOWING TYPES OF INFORMATION ARE SPECIALLY AUTHORIZED FOR RELEASED:

_____

_____

_____

EXPIRATION DATE OF THIS AUTHORIZATION: _____/_____/_____

_____ _____
(Patient's Signature) (Date)

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