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AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

I _____ consent to allow Dr. Wesley Johnson, Dr. Daniel Heiner, Dr. Scott Graham, Dr. William Binder, Dr. Ronald Killian or representative thereof to discuss or share medical information (including but not limited to calling to inquire appointment dates, treatment dates, medication refills, medical progress, etc) with the following people:

Name Relationship Phone Number

Name Relationship Phone Number

Name Relationship Phone Number

Name Relationship Phone Number

Name Relationship Phone Number

Patient Signature

Date