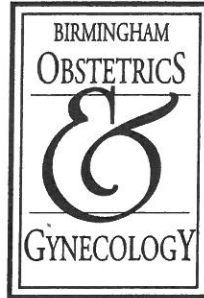


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INFORMATION TO USED OR DISCLOSED:

_____ Entire Record
_____ Last 2 Years
_____ Lab Work
_____ Pap Smear
_____ Other _____

PURPOSE OF DISCLOSURE:

_____ Changing Doctor
_____ Moving
_____ Personal
_____ Other

* Unless you sign here, No information about alcohol/substance abuse, HIV/AIDS or mental health issues, including ADD and ADHD will be disclosed.

One signature required here (ANY PATIENT AGE 14 AND OVER MUST PROVIDE THE SIGNATURE HERE)

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No, do NOT disclose this information _____

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This authorization is effective through _____ / _____ / _____ / unless revoked or terminated earlier by the patient or patient's representative.

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