

WITNESS

## **AUTHORIZATION TO RELEASE PROTECTED HEALTHCARE INFORMATION**

	Date of Birth:		Telephone:	-
dress:				
Street	City		Zip	_
I request and authorize SNE and Dr				
to release healthcare information of the pa	atient named above to:			
Name/Facility:				
Address:				
Street	City		Zip	
Phone #:	Fax	#:		
		· · · · ·		_
This authorization is being requested for the		-		
Medical Care Legal				
Other (please describe):				_
			my medical record may contain informat	
nsidered sensitive under the law. My check man seleased. I understand that if I do not check the law. HIV/AIDS	rk(s) below indicate(s) t	<u>hat I do</u> th will re	NOT permit information of this type, if it	exis
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Date