AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Date _____

Patient's Name _____

SSN_____

Date of Birth_____

I request and authorize Ballantyne Medical Associates to release healthcare information of

the patient named above to:

Name/Phone/Relationship

_____

_____

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Name/Phone/Relationship

_____

_____

__

Name/Phone/Relationship

_____

_____

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This request and authorization applies to:

_____

All healthcare information please check

Patient Signature ____

Date___________________________