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## PERSONAL/PRIVATE HEALTH INFORMATION RELEASE REQUEST

Patient Name: _		D.O.B.:	
I,and all of my per	, authorize V rsonal/private health in	Vright & Associates l formation to:	Family Healthcare and/or his agent(s) to release any
Legal Name		<u> </u>	Relationship
Legal Name		<u> </u>	Relationship
Legal Name			Relationship
Legal Name			Relationship
	t some information con is release/request must	•	nay be sensitive in nature. I also understand that
	Date:	Signature:	