FAMILY PRACTICE PHYSICIANS, INC.

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Due to HIPAA regulations, we are unable to talk to anyone but the patient regarding your medical condition(s) without a signed release. If you would like us to talk anyone regarding your medical condition(s), please complete this form.

I hereby authorize Family Practice Physicians staff to discuss my medical condition(s) with:

____

Name and relationship

This authorization may be revoked in writing at any time.

____ ______________________

Patient Signature Date

____

Printed Name

____

Witness