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Release of Information Form

If you wish to have a family member, power of attorney, etc. discuss any aspect of your medical care with our providers and staff, please sign below and indicate to whom we may speak.

☐ **Check this box if you decline authorizing permission to others.**

I give permission to Scott A. Fleischer, M.D., P.C., & Associates to discuss my medical care with ______________________________, who is my ______________________________.

______________________________ ______________________________

Print name of individual **Relationship**

______________________________ ______________________________

(Signature) **Date**