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### **AUTHORIZATION TO RELEASE MEDICAL RECORDS**

I hereby authorize Stone Oak Ophthalmology Center to disclose my complete ophthalmic records to:

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In furtherance of this authorization, I do hereby waive all provisions of law and privileges relating to the disclosures hereby authorized.

Dated this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

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Patient's name (please print)

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Patient's Date of Birth

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Patient's signature (or responsible party)