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ORAL, FACIAL & IMPLANT SURGERY

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Authorization to Share Health Information

Patient's name: _____

I authorize Dr. Stewart, Dr. Arango, and office staff to discuss my care with the persons listed below:

Name: _____

Relationship: _____

Name: _____

Relationship: _____

Name: _____

Relationship: _____

Name: _____

Relationship: _____

Name: _____

Relationship: _____

_____ _____

Signature of patient or patient's representative Date