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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)**