

CONSENT TO RELEASE PERSONAL HEALTH INFORMATION

I, hereby, authorize \_\_\_\_\_

\_\_\_\_\_

to receive and/or discuss my personal health information with Vallemont Surgical Associates.

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date

May leave an answering machine message - Yes \_\_\_ No \_\_\_

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