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Authorization Regarding Release of Information

I, ___________________________________Date of Birth ____________, hereby give
(Patient Name, please print)

Southeastern Endocrine & Diabetes, P.C. permission to release my Protected Health Information regarding medical treatment and/or financial accounting information to the following individuals:

□ Medical Treatment □ Financial Account

Name of Authorized Person	Relationship
____	__________________
____	__________________
____	__________________

____ __________________
Patient Signature Date