

Allison Paige Young, M.D.// Jana Nicole Waters, M.D.

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**AUTHORIZATION TO RELEASE MEDICAL RECORDS**

I hereby authorize **Allison Paige Young M.D.//Jana Nicole Waters, M.D.**

todisclose my complete ophthalmic records to:

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In furtherance of this authorization, I do hereby waive all provision 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)