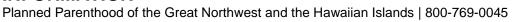
AUTHORIZATION FORM FOR RELEASE OF HEALTH INFORMATION





Patient Name:				Medical Record #:		
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Date of birth:	/	/	Social Secu	ırity #:		
Address:			City:		State:	Zip:
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	ised may includ	e informatior	n regarding testi			AIDS, sexually transmitted or this information to be
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Authorization at a it will be effective Hawaiian Islands	on will expire on any time by noti e on the date no s has already ac	e year from fying Planne tified except tted upon suc	d Parenthood of to the extent tha ch Authorization	the Great North at Planned Paren . Information use	nwest and the Haw nthood of the Grea	I may revoke this aiian Islands in writing, and t Northwest and the rsuant to this Authorization ulations.

Signature of client

Date