		Hiref	MI
Address:	Last	First	IVII
	Street		
	City	State	Zip
Date of Birth:		Telephone #:	
I,	Month/Date/Year		(Area Code) Number
(Patient, Parent, G	autl buardian or Legal Rep.)	horize (Name of Physici	an/health care provider)
	MaríMed and		
include:	ng to my identity, diagnosi		mation to released shall
Office visit note	s (within past two years) re	e: diagnosis/treatment of:	
Current Active 1	Problem List		
Letter from trea	ting physician attesting on	going treatment for speci	fied condition
Medication lists			
Medication lists	/notes/sheets		
	/notes/sneets he following purposes(s):		
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