BEHAVIORAL VISION, LTD.

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Permission to Release Patient Records

Attention: _____

Patient: _____

Date: _____

I grant permission to this office to release my patient records to:

_____

_____

The medical findings and treatment disclosed should cover the period of time from _____ to _____. In initiating this request, I hereby release my practitioner from laws governing the disclosure of confidential or privileged information.

_____

Signature of patient or authorized representative