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Under the HIPPA Privacy Act, I hereby authorize Dr. David Bortniker of Ear, Nose, and Throat Care PC to release any and all medical information necessary to the following person(s):

Name: _____ Relation:_____

Name: _____ Relation:_____

Note from patient (IF NO RESTRICTIONS WRITE "ALL RECORDS"):

_____

_____

Patients Name: _____ Date of Birth: _____

Patients Signature: _____ Date:_____