Kathleen Choe
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Authorization to Obtain/Disclose Health Information

Name of client DOB SSN

Signature signifies permission to _____obtain _____disclose health information from/to:

Name of provider Phone Number

Name of provider Phone Number

Name of provider Phone Number

Name of provider Phone Number

This authorization expires one year from _____
Today's date

I may revoke this authorization at any time prior to its expiration by sending written notification to the parties listed on this form.

Signature of client