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PATIENT AUTHORIZATION TO RELEASE INFORMATION

I HEREBY AUTHORIZE MY Attending Physician and/or hospital to release any information, or copies thereof, acquired in the course of my examination or treatment to my employer and/or his representative.

Patient's Name _____

Patient's Signature _____

Date _____

FORWARD COPY WITHIN 24 HOURS OF INCIDENT TO MANCON® CORPORATE OFFICE
HUMAN RESOURCES ATTN: LAURA SIPES – FAX 757-457-9345 or EMAIL LSIPES@MANCONINC.COM

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