Lanier Family Healthcare

Gary S. Orris M.D. *Kasin Anton, P.A.-C*

Authorization to release information to Family Member or Friend

I, _____, am authorizing Lanier Family Healthcare
(Patient's Name)

to release any of my medical information to _____, if they
(Family Member/Friend Name)

should call or write on my behalf. This authorization is effective _____
(start date)

and will not expire until further notice in writing.

Signature_____ Date_____
(Patient's Signature)

OPT to Decline _____

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