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AUTHORIZATION FOR RELEASE OF INFORMATION

RE:	ADDRESS:
Name of patient DATE OF BIRTH:	
THIS WILL AUTHORIZE:	
<u>6525 FRANCE</u>	GOLOGY, HEAD AND NECK SURGERY, P.A. E AVENUE SOUTH, SUITE 325 DINA, MN 55435
TO RELEASE INFORMATION TO:	
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I understand that I may revoke this above stated purpose(s), consent widate of signature without my expres	consent at any time and that upon fulfillment of the lautomatically expire three (3) months following the is revocation.
(Signature of patient/guardia	(Relationship to patient)
(Witness signature)	(Date)

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