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RELEASE OF INFORMATION FORM

I, _____, authorize Dr. Michelle Wedig to disclose/release information for the purpose of my treatment to/from:

| Name | Relationship | Address | Phone |
|------|--------------|---------|-------|
|------|--------------|---------|-------|

I understand this authorization expires on _____ (or 1 year from today) and can be revoked by me at any time.

Signature

Date