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CONSENT TO RELEASE INFORMATION TO MY FAMILY / OTHERS

Dennis H. Kim, M.D., LLC, and staff have my permission to discuss or release information about my health, medications, treatment plans, laboratory and other test results, or other matters related to my care in this practice, to the following people:

Name _____

Relationship to patient _____

Name _____

Relationship to patient _____

Name _____

Relationship to patient _____

Name _____

Relationship to patient _____

Name _____

Relationship to patient _____

This consent will remain in effect until changed in writing by me.

Patient Name (print) _____

Patient Social Security # (or date of birth) _____

Signed _____ Relationship to patient _____

Name (Printed) _____ Date _____