

Dr Martina Popelkova

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relocated to

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**Southern
Healthcare
Specialists**

Consent to Release Medical Information

Patient Full Name: _____

Date of Birth: _____

Address: _____

Phone: _____

Email: _____

This letter is to advise that (Patient Full Name)_____ or their

Parent/Carer, has granted permission for Dr Martina Popelkova (current treating medical physician) to release medical information to the below physician/practice.

**Required Fields*

***Dr Full Name:** _____

Practice Name: _____

***Address:** _____

***Phone:** _____

***Fax:** _____

Email: _____

Patient or Parent/Carer Signature: _____

Parent or Parent/Carer Full Name: _____

Date: _____