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ADDITIONAL DISCLOSURE AUTHORITY

In addition to the allowable disclosures described in the statement of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the persons indicated below.

<i>Any Member Of My Immediate Family</i>	YES _____	NO _____
<i>Spouse Only</i>	YES _____	NO _____
<i>Referring Physician</i>	YES _____	NO _____
<i>Other (Please specify)</i>	YES _____	NO _____

Name of Patient or Personal Representative

Signature of Patient or Personal Representative

Date _____