Victor E. Mendoza M.D.
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Release of Patient Information Consent

I _____ , hereby authorize this office:

_____

_____

_____

To discuss my medical care and records with:

_____

_____

_____

_____ _____

Print Patient's Name Date

_____ _____

Signature of Patient/Parent/Guardian Date

_____ _____

Witness/Clinician/Physician Signature Date