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I, \_\_\_\_\_, \_\_\_\_\_  
Name of Patient Date of Birth

**GIVE PERMISSION TO MICHAEL J. BARNTHOUSE, M.D. TO DISCUSS MY  
MEDICAL CARE, AS SPECIFIED BELOW, WITH THE FOLLOWING  
INDIVIDUAL(S):**

\_\_\_\_\_  
Name Relationship to Patient

\_\_\_\_\_  
Name Relationship to Patient

\_\_\_\_\_  
Name Relationship to Patient

\_\_\_\_\_ ANY & ALL INFORMATION  
\_\_\_\_\_ INFORMATION REGARDING DATE(S) OF SERVICE(S): \_\_\_\_\_  
\_\_\_\_\_ INFORMATION REGARDING DIAGNOSIS &/OR TREATMENT OF: \_\_\_\_\_

THIS AUTHORIZATION WILL REMAIN IN EFFECT UNTIL REVOKED IN WRITING.

\_\_\_\_\_  
Signature of Patient Today's Date