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BOARD CERTIFIED	BOARD CERTIFIED	BOARD CERTIFIED
FAMILY PRACTICE	FAMILY NURSE PRACTITIONER	FAMILY NURSE PRACTITIONER

CONSENT TO AUTHORIZE ALTERNATE COMMUNICATION

Patient Name: ____

Chart No.: ____

Date of Birth: ____

I authorize Clayton Medical Associates to disclose to, and discuss with, medical information to the person(s) listed below that is (are) involved in my medical care:

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______________________________ ______________________
Signature of Patient Date

March 28, 2016