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Patient:	Date:	
I grant permission to the office of		to release my patient records to
the office of Jesselyn Michaud, O.D. and	d Abigail Hilvers, O.D.	
I do hereby release my practitioner from information.	n any laws governing the disclosur	e of confidential and/or privileged
Signature:		
(Signature of patient or a	authorized representative.)	