

Glandorf Vision Group, Inc.

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Release of Medical Information

I consent that my medical information may be released/shared, upon request to the following people:

Name	Relationship
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____

Or: I do not consent that my medical information may be released to anyone. _____

Signature: _____ Date: _____