Emerald Coast Family Medicine

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I, _____, give my permission for my designated representative, _____ (phone#_____) to receive information regarding my medical condition as diagnosed by Dr. Castaneda, M.D. This information may be written or in oral form. I may revoke this permission in writing at any time and agree not to hold Dr. Castaneda, M.D. or his office responsible for any information which is released prior to the receipt of a document of revocation.

Signed: _____

Date: _____

Witness: _____