

Muir Obstetrics & Gynecologic Medical Group, Inc.

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Sarah Noble, RN, MS, FNP ♦ Linda Fung Shui, RN, MSN, FNP

To: Muir OB/GYN

I hereby authorize Muir OB/GYN to release all aspects of my medical history, lab results, sonograms and on-going medical care to (name) _____
(relationship) _____ and (name) _____
(relationship) _____. Lab information excludes results of HIV and Genetic Testing, which can only be given to the patient in person.

I authorize confirmation of any appointments I have.

This authorization is valid for one year to date.

Patient Name: _____

Patient Signature: _____

Date: _____

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