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Medical Records  
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## PERMISSION TO DISCUSS

To: Pit River Health Service, Inc., Providers and/ or Staff Members

I, \_\_\_\_\_, (DOB) \_\_\_\_\_, by way of my signature below, do hereby give Pit River Health Service, Inc., its providers, staff members and representatives therein, permission to discuss scheduling, pertinent information, prescriptions and medications and any other medical and/ or dental issues or concerns with my appointee(s):

Appointee Name \_\_\_\_\_ (DOB or ID #) \_\_\_\_\_

Appointee Name \_\_\_\_\_ (DOB or ID #) \_\_\_\_\_

Appointee Name \_\_\_\_\_ (DOB or ID #) \_\_\_\_\_

Appointee Name \_\_\_\_\_ (DOB or ID #) \_\_\_\_\_

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

**This is only valid for one year from date signed!**

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