mississippibreastcenter.com
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DUE TO HIPPA REGULATIONS WE ARE UNABLE TO DISCUSS YOUR MEDICAL OR FINANCIAL CARE WITH YOUR FAMILY MEMBERS OR FRIENDS WITHOUT YOUR WRITTEN PERMISSION. PLEASE DESIGNATE BELOW WHO YOU WANT US TO TALK WITH ON YOUR BEHALF.

THANK YOU.

I ____*YOUR NAME HERE*____ give full authorization for the following person(s) to obtain any medical or billing information.

________________________ RELATIONSHIP ________________________

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(PRINT) PATIENT'S NAME

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(SIGN) PATIENT'S SIGNATURE DATE