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AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize M. Christina Benson, M.D., to obtain and release all information on:

Name _____ Address _____

I authorize and request the following individuals and agencies to release information on the person named to Dr. M. Christina Benson. I also authorize Dr. Benson to release information on the person named to the following individuals and agencies.

Individual _____ Address _____
Agency _____
Telephone _____ Fax _____

Individual _____ Address _____
Agency _____
Telephone _____ Fax _____

Signature _____ Date _____