PERMISSION TO SPEAK

Date: ______________________________

I ___________________________________, (Date of Birth _________) hereby give my permission for **Dearborn Allergy & Asthma Clinic, PC** to give my medical and billing information to:

____

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This permission is to expire on: __________________________ unless I give **Dearborn Allergy & Asthma Clinic, PC** written notice to revoke this contract.

____
Patient's Signature

____
Printed Name