SHERI SPIRT, M.D.

PSYCHIATRY

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Date

I hereby authorize\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Provider of information)

to release any and all information about me to Dr. Sheri Spirt for the purpose of completion of evaluation or for updating records. These should include all of my most recent medical records, including my most recent physical examination and lab reports. The information should be sent to the above address or faxed to the above fax number. Thank you in advance for your cooperation and promptness.

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(Printed name of patient)

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(Signature)

Please send to your PCP for your most recent medical records.

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(Witness)