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By signing, I am acknowledging that I have disclosed my relevant health information including all information now within my knowledge, and have provided accurate and complete personal information.

- By checking this box, I give permission to be contacted at my home to receive confirmation of office appointments, or any other information relating to my care. If I do not check this box, I understand that I may not receive all relevant health results as rapidly as if I had granted the permission.**

X _____
Patient Signature

Date