Robert W. Ullman, ND
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Date__________

To: Physician, Therapist, family member or Health Care Provider:

Name:____

Address:____

City, State and Zipcode:____

To whom it may concern:
I, _______________________________authorize _________________________

____
to share information and/or records with Drs Ullman or Dr. Judyth Reichenberg-Ullman in connection with my treatment while under their care.

Patients printed name:____

Any other names which records might be listed:________________________

Date of birth:________________

Patients signature:____