

AZUSA PACIFIC UNIVERSITY HEALTH CENTER
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DATE:

TO WHOM IT MAY CONCERN:

I, _____, GIVE AZUSA PACIFIC UNIVERSITY HEALTH CENTER

PERMISSION TO RELEASE MY RECORDS AND/OR TO SPEAK OPENLY TO MY PARENT/PARENTS,

_____.

EXCEPTIONS WOULD BE:

_____.

PRINT NAME AND DATE OF BIRTH

SIGNATURE

DATE

WITNESS

DATE