



Kenmar Pediatrics

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Your Community Partner

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Lab/X-ray Authorization Release Form

Patient Name _____

Parent Name _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

May we leave a message on your voicemail? At Home At Work Cell

Medical information may be given to (if other than parent) _____

No one except myself or spouse _____

The following persons:

Parent Signature: _____

Date: _____