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TODD MACGREGOR, BSc, MSc, MD, FAAP, FRCP(C) (Consulting Pediatrics)

Date: _____

Dear Dr. _____

This will authorize you to release any information regarding my health to:

Name: _____

Address: _____

Phone: _____

Fax: _____

Yours truly,

Signature

Witness: _____

Name: _____

Print

Address: _____

Phone: _____