.

I authorize the following individual or organization to exchange the above named individual's medical/educational information as described below:

Individual or Organization:	Individual or Organization:
_____ _____ *Address* _____ *City, State, Zip Code* *Telephone:* _____ *FAX:* _____	_____ _____ *Address* _____ *City, State, Zip Code*

nformation
Valid for medical information

Duration: