SHERI SPIRT, M.D.

PSYCHIATRY

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DATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I,\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_HEREBY AUTHORIZE DR. SHERI SPIRT TO SEND ALL COPIES OF MY MEDICAL RECORDS AND OR NOTES TO MY PRIMARY CARE PHYSICIAN, DR. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_AS WELL AS ANY OTHER TREATING PROFESSIONALS INVOLVED IN MY CARE TO HELP AID IN MY TREATMENT.

Patient Name

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Patient Signature

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Witness