Susan K. Buenaventura, M.D., F.A.C.S.
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Authorization for the disclosure of information

I authorize Dr. Susan Buenaventura to disclose complete information concerning her medical findings and the treatment of the undersigned, from the initial office visit until the date of the conclusion of such treatment to those individuals who, in Dr. Susan Buenaventura's sole determination, are required to receive such information for the purpose of medical treatment, medical quality assurance, and peer review.

Signature: _____ **Date:** _____