AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

I, _____ , hereby authorize:
Name of Patient

Name of practice or doctor: _____

Address: _____

_____

Phone and fax number: _____

E-Mail address: _____

To release information contained in my dental records to:

Name of practice or doctor: _____

Address: _____

_____

Phone and fax number: _____

E-Mail address: _____

Please provide X-rays from the last 5 years and any other information that would be useful for future

Sincerely,

_____
(Full Name)

_____ _____
(Signature) (Date)