AUTHORIZATION TO RELEASE PATIENT INFORMATION

Patient Name: _____ Birthdate: _____

Address: _____ SS# _____

City/State/Zip: _____ Phone: _____

Other names under which records may be listed: _____

I authorize _____
to release / receive (circle one) copies of my radiographs and any pertinent information regarding past dental treatment that you may have at your institution.

Name and address of person or organization to / from (circle one) whom disclosure is to be made:
_____

Patient Signature: _____

Witness: _____

Date: _____