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Diplomate, American Board of Oral and Maxillofacial Surgery

AUTHORIZATION FOR RELEASE OF MEDICAL/DENTAL RECORDS

PATIENT'S NAME: _____

I hereby request and authorize the release of all information, without limitations, regarding any physical and medical condition, as revealed by your observation or treatment, past, present or future.

This includes photocopies of medical and/or dental histories, x-ray findings, diagnosis, treatment, prognosis and financial records.

I request that you release the above information to: All medical and dental doctors,

PLEASE PRINT NAMES OF FAMILY MEMBERS OR SIGNIFICANT PERSON AUTHORIZED TO INQUIRE ON YOUR BEHALF.

Father: _____
Mother: _____
Spouse: _____
Other Family Member: _____
Friend, Name: _____

_____

Patient's (legal Guardian) Signature Date