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Dental/Medical Information Release Form

Name: _____ Date: _____

Release of Information

Please check appropriate line

___ I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

___ Spouse/Parent - Name _____

___ Child(ren)-Name(s) _____

___ Other - Name_____
- _____ Insurance Company
- _____ Dentist
- _____ Medical doctor

___ Information is not to be released to anyone

This **Release of Information** will remain in effect until terminated by me in writing.

Signed: _____

Date: _____