Authorization for the release of information

I hereby authorize __________________________ to forward my dental history, in accordance with their release-of-information policies from the dental record of

______________________________ (Name of Patient) _______________ (Date of Birth) concerning treatment received on or about

______________________________ (Dates of Service) to the following: Alicia Matayoshi DMD, 7807 Baymeadows Rd. E, Suite 304, Jacksonville, FL 32256
(904) 854-2300

I understand that my authorization releases your office from all legal liability that may arise from disclosure to the requested information.

____
(Date)

____
(Signature of patient or nearest relative/guardian, If patient is unable to sign due to mental or physical Condition)

PLEASE CHECK THE SPECIFIC DENTAL INFORMATION NEEDED

____________ Progress Notes

_______ Periapical Films

__________FMX/Pano

____________ Bitewing Films

_______ Dental Charting