# 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

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

_____ to the following: Alicia Matayoshi DMD, 7807 Baymeadows Rd. E,
(Dates of Service) 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)

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## PLEASE CHECK THE SPECIFIC DENTAL INFORMATION NEEDED

_____ Progress Notes _____ Periapical Films _____FMX/Pano

_____ Bitewing Films _____ Dental Charting