THE DENTAL LAB

Dr. Karen Erani, DMD

AUTHORIZATION FOR RELEASE

AUTHORIZATION FOR RELEASE OF MENTAL/DENTAL RECORDS

Patient's Name _____

Date Requested _____ /_____ /_____

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

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

_____

(Fill in the NAME OF PATIENT of subsequent doctor or attorney)

_____

Address

_____

Address (line 2)

_____

City State Zip code

_____

Patient (or Legal Guardian)'s Signature

_____

Signature of Witness