Authorization for Release of Information

RE: ____

FIRST & LAST NAME DOB

____

ADDRESS

I hereby authorize & request:

510 East State Street
Mauston, WI 53948
Phone (608)847-5614 Fax (608) 847-7265
Email: improveyoursmile@wdimprovements.com

Release To:______ **Obtain From:______**

____

Name

____

Address

____

City, State, Zip Code

Purpose of Disclosure

I understand the specific information to be disclosed includes a detailed report of examinations, finding, treatment, prognosis and copies of any and all other records pertaining to me or my dependent(s). This consent is effective until I submit a written cancellation.

____

Signed *Date*

Parents or guardians must sign for minor children or dependents. Each adult (18 or over) must complete and sign a separate form.