BAXTER DENTAL

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AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

Patient Name:_____Date:_____

Address:_____

Phone Number:_____ Birth Date:_____

I hereby authorize _____to release any diagnostic x-rays into my own keeping or to the following individual or organization.

Name:_____

Address:_____

City:_____State:_____Zip Code:_____

Phone Number:_____

The facility, its employees and the attending dentist are released from legal responsibilit or liability for the release of the above information to the extent indicated and authorizec by this release. I am accepting responsibility for these records and for the protection of my own right of medical record confidentiality.

_____ _____
Signature of Patient Date of Signature

_____ _____
Signature of Person Authorized to sign, other than Patient Relationship to Patient