



Mitchell V. Sabbagh DMD, PC

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AUTHORIZATION FOR RELEASE

AUTHORIZATION FOR RELEASE OF MEDICAL/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