SAMPSON DENTAL GROUP

Authorization to Release Information

Patient's Name:_____

Date of Birth:_____

Patient's Social Security Number:_____

I hereby authorize Sampson Dental Group to (check one):

_____ Obtain my records from the following

_____ Release my records to the following

Name:_____

Address:_____

_____

Email (if applicable):_____

I understand that my authorization will remain effective from the date of my signature. The information will be handled confidentially in compliance with all applicable federal laws. I understand that I may see the information that is to be sent, and that I may revoke the authorization at any time by written, dated communication.

I have read and understood the nature of this release.

_____ _____

Signature of authorizing patient/guardian Date