Authorization for the release of information

I hereby authorize _________________________ to forward my dental history, in accordance with their release-of-information policies from the dental record of

_____________________________ _______________ concerning treatment received on or about
(Name of Patient) (Date of Birth)

____________________________ to the following: Alicia Matayoshi DMD, 7807 Baymeadows Rd. E, Suite 304, Jacksonville, FL 32256
(Dates of Service) (904) 854-2300

I understand that my authorization releases your office from all legal liability that may arise from disclosure to the requested information.

________________________________ ____
(Date) (Signature of patient or nearest relative/guardian, If patient is unable to sign due to mental or physical Condition)

PLEASE CHECK THE SPECIFIC DENTAL INFORMATION NEEDED

___________ Progress Notes _______ Periapical Films __________FMX/Pano

___________ Bitewing Films _______ Dental Charting