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AUTHORIZATION TO RELEASE MEDICAL/DENTAL INFORMATION

Patient name ____ DOB ______________

I authorize to release my medical/dental records to:

My family **physician**______________________________________

Group name______________________________________

Town______________________________________

My family **dentist** ____

Group name ____

Town____

I authorize to release my medical/dental records to all medical/dental sources, including any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf.

This authorization, as may be applicable, extends to any medical/dental records covered by the privilege, including without limitation to psychiatric, psychological and mental testing and records; records relating to drug treatment and/or substance abuse; records to sexually transmitted diseases and/or social service notes.

Patient/Guardian signature _________________________________ Date ____________________

Update ---- Signature _____________________________________ Date ___________________

Update ---- Signature _____________________________________ Date ___________________

Update ---- Signature _____________________________________ Date ___________________