PATIENT AUTHORIZATION

FOR USE/DISCLOSURE OF HEALTH CARE INFORMATION

Patient Name____________________________ Date of Birth___________________

I request and authorize ____ to release health care information of the patient named above to:

Anderson Family & Cosmetic Dentistry
453 136th Ave
Holland, MI 49424

frontdesk@andersonfcd.com

This request and authorization applies to:

- ▫ **Current X-rays**
- ▫ **Health care information relating to the following treatment, condition, or dates of treatment:**

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Signature of patient or authorized representative Date signed

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Relationship to patient