MINSTER DENTAL CARE

Dr. Philip Slonkosky
Pediatric Dentistry
at Minster Dental

Diplomate, American Board of Pediatric Dentistry   Advancing the Science and Art of Pediatric Dentistry

AUTHORIZATION FOR RELEASE OF PATIENT RECORD INFORMATION

TO Minster Dental Care

Name of Patient: ____

Address of Patient: ____
Number & Street   Apt.

____
City   State   Zip

Social Security #: _____-____-_____   Date of Birth:___/____/____

I hereby authorize: ____
(Name of doctor, hospital or dentist RELEASING information)

to RELEASE TO Minster Dental Care

the following information:______________________________________

____

covering the period of care from ______________ to _______________.

I understand I may revoke this consent at any time except to the extent that action has already been taken on it and that it will expire automatically ninety (90) days from the date below.

____, by releasing authorized information, is hereby relieved from all legal responsibility or liability for the release of the information described above to the extent indicated and authorized herein.

__________________________________   _________________________
Signature   Date