Teague Dentistry Authorization to Release Health Information

teaguedentistry@gmail.com

Patient Information:

Name of Patient:____ DOB: _____________________

Address:____

City, State, Zip Code:_____________________________________ PHONE:____________________

Teague Dentistry may release/receive the following information:

__Entire record __Financial records __Office visit notes __Diagnostic studies (x-rays)

Entity or person who will receive the information:

Name:____

Fax / Email : ____

Address:____

City, State, Zip Code:____

This authorization shall be in effect until the information has been forwarded as requested or until the course of treatment is complete.

____ Date: _______________________

Signature of Patient or Personal Representative