AUTHORIZATION TO RELEASE INFORMATION

Patient's Name: _____ Date of Birth: _____

Parent/Guardian's Name: _____

I request and authorize **Spangler, Rohlfing and Lambert DDS, PLLC** to release information of the patient named above to:

Name: _____

Address: _____

Email: _____

City: _____ State: _____ Zip Code: _____

This request and authorization applies to:

☐ Dental information relating to the following treatment, condition, or dates: _____

_____

☐ All current x-rays

☐ Other: _____

Parent/Guardian's Signature: _____ Date Signed: _____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.

If faxing, please send to 336-464-2902

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