26601 Coolidge Hwy Oak Park, MI 48237 Phone (248) 352-2266 Fax (248) 352-2267

Authorization for Release of Dental Records

I, ___________________________ on behalf of ______________________________, authorize
(Patient/Legal Guardian) (Patient's Full Name)

___Dr. Mark A. Wolfson___ to release dental record information (as indicated below)

to ____at ____
(Name of doctor/entity) (phone number)

____
(Email Address)

Please **initial** the appropriate box to authorize release of dental records:

______ X-Rays

______ Any and all of my dental record (as of the date of this release)

______ Any and all of my dental record EXCEPT the following:

____

This release is effective from the date of execution, however, it may be revoked by me at any time by providing notice in writing to the above named party.

X _________________________________ _______/______/_________
(Signature of Patient/Legal Guardian of Patient) (Date)

Please submit this form in person, by mail or email at drwolfson@hotmail.com