AUTHORIZATION FOR RELEASE OF INFORMATION

I HEREBY AUTHORIZE:

_____

Name of Dentist/Office

_____

Address

_____

City State Zip Code

TO RELEASE MY RECORDS/RADIOGRAPHS TO:

New Town Dental, P.A. / Dr. Harry Snydman
9419 Common Brook Rd., Suite 218
Owings Mills, MD 21117
410-654-9696
410-654-9686 (fax)
info@newtowndental.com

PATIENT NAME: _____

ADDITIONAL FAMILY MEMBERS: _____
_____
_____

I UNDERSTAND THAT I MAY CANCEL THIS AUTHORIZATION AT ANYTIME, EXCEPT IF ACTION HAS ALREADY BEEN TAKEN BASED ON THIS AUTHORIZATION. I ALSO UNDERSTAND THAT THIS AUTHORIZATION WILL AUTOMATICALLY EXPIRE THREE MONTHS FROM THE DATE BELOW.

_____ _____
Signature of Patient, Parent, or Legal Guardian Date