AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name_____ Date of Birth_____

The person named above is or has been a patient of

Name of Facility: East Wichita Dentist
Address: 8150 E. Douglas Ste. 10, Wichita, KS 67206
Phone: 316-686-7395

The person named above hereby authorizes East Wichita Dentist to release information regarding:

□ All information regarding assessment, diagnosis, financial information, and treatment of patient's condition, concern, or disease (specify):
_____

□ All information regarding care received by patient.

□ Financial information

□ Other information (specify):

to the following people:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Phone Messages:

□ I allow East Wichita Dentist to leave a message on my Voice Mail
□ I do not allow East Wichita Dentist to leave a message on my Voice Mail

_____
Print

_____ _____
Signature Date