COLLEGE HILL DENTAL

RELEASE OF INFORMATION

*Name of Patient*_____ *DOB:* _____

I hereby authorize College Hill Dental to disclose records

Obtained in the Course of my dental diagnosis and treatment to:

_____

_____

_____

I understand that the requester may not further disclose the information unless another authorization is obtained from me or unless discloser is specifically required or permitted by law.

Signed: _____ *Date:* _____

If other than patient please indicate relationship: _____

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