AUTHORIZATION FOR RELEASE OF DENTAL INFORMATION

George R. Schneeberger, D.D.S.
5100 S. Pennsylvania Ave., Lansing, MI 48911
(517) 887-0156
E-mail Address: schneebergerdds@att.net

I, _____authorize_____
to release the following dental information to George R. Schneeberger DDS

Please initial the appropriate category:

_____Any and all of my dental record (as of this date of release)
_____Intraoral complete series / panoramic film / bitewing films
_____Any and all of my dental record except the following: _____
_____

This release also specifically allows the release of the following information (this information will not be released unless the appropriate line is initialed):

_____Any record of treatment for drug and/or alcohol dependency or abuse;
_____Any record of mental health treatment
_____Any record of testing, care, treatment, reporting or research pertaining to infection with HIV or related diseases.

This information is being released for the following purpose(s) only: _____
_____and may not be used for another purpose or released to any other person(s) without my written consent.

This release is effective for six months 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.

S/_____ Date_____
Patient/Legal Guardian of Patient

S/_____ Date_____
Witness

Patient Name: _____ Dentist: _____
Date of Birth: _____
Address: _____
_____
_____ Phone: _____
Phone#:_____ E-mail Address_____
Transferring To: _____
From: _____