



## MEDICAL INFORMATION AUTHORIZATION

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I, \_\_\_\_\_ authorize the personnel of The Tooth Fairy to release all relevant information to the family members, personal representatives, friends, or other people listed below.

I may revoke this authorization by phone or in writing at any time.

Name:	Relationship to Patient:	Phone Number:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_