Wellesley Endodontics

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AUTHORIZATION FOR RELEASE OF PROTECTED INFORMATION

Patient Name_____ Date of Birth_____

Please complete this form thoroughly. You or your dependent's dental records cannot be released until this form is completed and signed by the patient (or if under 18 their parent or legal guardian).

I hereby authorize: Wellesley Endodontics, P.C. to release the following: Individually identifiable health information, X-rays, case report(s).

This authorization is valid for 1 year and may be revoked at any time in writing prior to the expiration date. Additional authorization for disclosure beyond the recipient is required.

Patient, Parent or Guardian Signature

Date

Witness Signature