Luck Dental Clinic, Inc.

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Authorization for the release of dental information

To: ____
Health Care Provider

____
Street Address

____
City State Zip Code

(_____)__________________________________
Telephone no.

You are hereby authorized to release to ____________________________ and its representatives any and all information you may have concerning my dental condition, including x-rays, which you have obtained as a result of history, examinations, testing, diagnosis, treatment and prognosis.

This authorization shall remain valid for one year from today's date. A signed copy of this authorization and DO / DO NOT (circle one) request a copy, and if requested, do acknowledge a receipt thereof.

I have read this authorization before signing it.

____
Print or type name

______________ ____________________________________
Date Signature

If not signed by the patient, please indicate relationship:
[ ] parent or guardian of minor patient
[ ] guardian or conservator of incompetent patient
[ ] beneficiary or personal representative of deceased patient