SUMMIT COSMETIC DENTISTRY
425 S. SUMMIT AVE.
FORT WORTH, TEXAS 76104
(817)335-3393

# MEDICAL INFORMATION RELEASE FORM

NAME:_____

DATE OF BIRTH:_____

Release of Information

( ) I authorize the release of information including the diagnosis, records, examination rendered to me and claims information. This information may be released to:

( ) Spouse:_____
( ) Children:_____
( ) Other: _____
( )Information is not to be released to anyone.

This **RELEASE OF INFORMATION** will remain in effective until terminated by me in writing

The best way to contact or to leave messages for me:
( ) My home
( ) My work
( ) My cell number
( ) Other

If unable to reach me:
( ) You may leave a detailed message
( ) Please leave a message asking me to return your call
( ) Other:_____

Signed:_____ Date:_____