



**DENTAL  
ASSOCIATES**  
OF WALPOLE

Family ◦ Specialty ◦ Care

**AUTHORIZATION TO RELEASE INFORMATION**

DATE: \_\_\_\_\_

I, \_\_\_\_\_, date of birth: \_\_\_\_\_, give my permission to Dental Associates of Walpole to discuss treatment provided and treatment recommended with the persons listed below until such time as I notify Dental Associates of Walpole in writing that I am rescinding this authorization:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Signed: \_\_\_\_\_