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: ____