AUTHORIZATION TO RELEASE MEDICAL INFORMATION
TO FAMILY MEMBERS, POWER OF ATTORNEY, ETC.

I, ____ authorize Oceans Dental PC to release any and all information pertaining to my care, including but not limited to, future appointments, treatment plans, prognosis, ect., to the following individuals:

- If permission given: list the name(s) of the individual(s) who will have the authority to receive any & all information pertaining to your care and then sign and date the form.
- IF YOU DO NOT WISH ANY INFORMATION TO BE RELEASED: DRAW AN “X” OVER THE THREE SECTIONS LISTED BELOW and then sign and date the form.

Name: ____

Relationship to Patient: ____

Name: ____

Relationship to Patient: ____

Name: ____

Relationship to Patient: ____

Patient Signature: ____

Printed Name of Patient: ____

Date: ____