AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Please complete this form thoroughly. You or your dependent's dental records cannot be released until this form is completed and signed by the patient (or if under 18 their parent or legal guardian.)

Patient Information: **PLEASE PRINT**

Patient Name: _____ Date of Birth: _____
Last Name First Name

Address: _____
Street City State Zip

I hereby authorize: _____

_____

_____

_____

To release the following individually identifiable health information: ***Please Specify***

ALL RECORDS or

Records Dated From: _____ To: _____

Other: _____

TO: **Drs. Perlman and Koidin, P.C.**
77 Broad Street
Lynn, MA 01902
(781) 599-2900

This authorization is valid for 90 days and may be revoked at any time in writing prior to the expiration date. Additional authorization for disclosure beyond the recipient is required.

_____ _____
Signature of Patient or Legal Guardian Witness Signature

_____
Date