COLLINS & MONTZ, D.M.D., P.A.

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

Name: _____

Address: _____

_____

SS#: _____ DOB: _____

Reason for Request: _____

I, _____, hereby authorize

Name: _____

Address: _____

_____

_____

to release x-rays and dental/medical information contained in my record to:

Collins & Montz, D.M.D., P.A.
524 Ocean Avenue
Melbourne Beach, FL 32951

If x-rays are digital, please forward films by e-mail to the following address:

collinsmontz@gmail.com

_____ _____

Signature of Patient/Parent (if patient is under 18years), Legal Guardian, or Authorized Representative

Date of Authorization

_____ _____

Signature of Witness

Date of Witness