



**LOUIS F. CLARIZIO, DDS PA**  
**ORAL SURGERY & DENTAL IMPLANT CENTER**  
 DIPLOMATE, AMERICAN BOARD OF ORAL & MAXILLOFACIAL SURGERY

**AUTHORIZATION TO RELEASE  
 MEDICAL INFORMATION**

From \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_ Cell \_\_\_\_\_ Fax \_\_\_\_\_

I authorize you to furnish a copy of medical records:

To \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

Limitations/Exclusions (if any) \_\_\_\_\_

**READ CAREFULLY**

I have authorized the release of all information and/or medical records to such diagnosis, testing or treatment, unless specifically excluded. I understand that you cannot limit or control the subsequent use or dissemination of medical information by the party to whom I request the information to be furnished. This request is a free voluntary act by me. I hereby release you and your staff from all legal responsibility that may arise from the release of the medical information hereby authorized.

Please list information that you are authorizing to be sent \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_

Patient/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Print Patient Name \_\_\_\_\_ D.O.B. \_\_\_\_\_

Maiden or Previous Name \_\_\_\_\_

SS# \_\_\_\_\_