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) ____________________

Email Address ____________________

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 ____________________

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Patient/Guardian Signature ____________________ Date ____________

Print Patient Name ____________________ D.O.B. ____________

Maiden or Previous Name ____________________

SS# ____________________

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