DANIEL E. ESPOSITO, MD, DMD, FACS
Board Certified Oral and Maxillofacial Surgeon
President of the Colorado Society of Oral and Maxillofacial Surgery

RELEASE OF INFORMATION AUTHORIZATION

By signing below, I authorize the Implant and Oral Surgery Center, the office of Dr. Daniel E. Esposito, MD, DMD, FACS to release the following information from the medical record of

____

to:

______________________________ (office name)

______________________________ (office phone number)

______________________________ (office fax)

______________________________ (office email)

The information to be released relates to the diagnosis and treatment rendered during the time period from ______________________ to ______________________.

The information to be disclosed includes:

__________ X-rays

__________ CT Scan

__________ MRI

__________ Other ____

I understand that the purpose of this disclosure is for use in:

- Future medical/dental care
- Insurance claim processing
- Legal claim processing

I also understand that this authorization is revocable except to the extent that action has already been taken, and this authorization will remain in force for until further notification is made.

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DATE **PATIENT OR GUARDIANS SIGNATURE**