IMPLANT and ORAL SURGERY Center

DANIEL E. ESPOSITO, MD, DMD, PC
Board Certified Oral and Maxillofacial Surgeon

RELEASE OF INFORMATION AUTHORIZATION

By signing below, I authorize ____ to release the following information from the medical record of ______________________________________ to Daniel E Esposito, MD, DMD. 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
- Other ____
-

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.

____
DATE PATIENT'S OR PARENT/GUARDIAN'S SIGNATURE

____
WITNESS SIGNATURE RELATIONSHIP TO PATIENT

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