wright smiles

gregory wright, dds | paola arcila, dds | victoria heron, dds

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AUTHORIZATION TO RELEASE HEALTHCARE/RECORDS INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize _____ to release healthcare information of the patient named above to:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

This request and authorization applies to:

☐ All Healthcare information and x-rays relating to the following treatment, condition, or dates: _____

_____

☐ All healthcare information

☐ Other: _____

.

Patient Signature: _____ Date Signed: _____