BEACONHILL
DENTAL ASSOCIATES

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Authorization to Release Health Care and Dental Information

Please print:

Patient Name	Date of Birth
Home Address	Home Telephone
City, State, Zip Code	Social Security Number

I hereby authorize_____, to furnish all health and dental information and release a copy of my entire dental record and x-rays to:

_____
(Person or organization to which disclosure is to be made)

_____
(Address, including city, state and zip code and/or email)

Signatures of Patient and Witness required. Please sign below:

Signature of Patient or Authorized Representative	Date
Signature of Witness	Date

(Please return this form by fax or mail to above address for Beacon Hill Dental Associates)