Authorization of Release

I authorize the release of a full report of examination findings, diagnosis, treatment program, etc., to any referring or treating health care professional. I additionally authorize the release of any medical information to insurance companies for legal documentation to process claims. I understand that I am responsible for all the charges for treatment to me regardless of insurance coverage.

Patient Printed Name: ____

Patient Signature: ____

Legal Guardian Signature if patient is a minor: ____

Date Signed:: _____/_______/_______

Area for Doctor and Staff Notations

Date Reviewed: _____/______/_______

Date Reviewed: _____/______/_______

Date Reviewed: _____/______/_______

Date Reviewed: _____/______/_______